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ABSTRACT

The National Alliance Concerned with School-Age Parents (NACSAP) is a private, non-profit, multidisciplinary membership organization specializing in technical assistance to those working with school-age parents, young families at risk, and sexually active youth. This publication represents a compilation of information relating to adolescent pregnancy. It views adolescence as a time of values testing, and brings together data from a number of surveys and studies. Topics include: needs and opportunities of school-age parents; evaluation of current programs; staff training needs and the role of technical assistance. (Author/BP)

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SCHOOL-AGE PREGNANCY AND PARENTHOOD IN THE UNITED STATES

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School-Age Pregnancy and Parenthood in the United States

A Report
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National Alliance Concerned with School-Age Parents
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by
Lucy Eddinger and Janet Forbush

about NACSAP

The National Alliance Concerned with School-Age Parents (NACSAP) is a private, non-profit, multidisciplinary membership organization specializing in technical assistance to those working with school-age parents, young families at risk, and sexually active youth. NACSAP's primary goals are to respond to immediate crises resulting from adolescent pregnancy and early parenthood and to work with community groups, parents, and agency representatives to develop programs and strategies which can help to prevent high-risk adolescent pregnancy. All membership dues and contributions are tax deductible. Membership fees are: Young Parents—$2/yr.; Individual—$20/yr.; Family—$30/yr.; Sustaining—$50; and Patron—$100. For further information contact:

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Summary

Although today's youth are frequently thought of as more inner-directed and self-assured, they are nonetheless subject to self-doubt, peer pressure, and values testing characteristic of normal adolescence. There is strong peer pressure to become sexually active at a very early age. However, such early sexual activity poses situations requiring a mature sense of judgment and decision-making ability for which the very young may not yet be prepared. Since contraception is not readily available in all parts of the country for this age group, fear of pregnancy is a constant factor. In addition, reluctance to admit sexual behavior makes it difficult for young people to use contraception even if it is available.

There is much information about the incidence of adolescent pregnancy but it is often confusing and written from a particular point of view. Teen pregnancy is frequently described as an "epidemic," conjuring up an alarming picture of a rapidly spreading disease. Statistically, there has been an actual decline in the teenage birth rate since the last baby boom of the late fifties, but the greater number of young women who are now of childbearing age cancels it out.

Overall, there is a seesaw effect in the birth rate among 10 to 19 year olds, with steady and substantial declines among 18 and 19 year olds offset by relatively unchanged rates among 15 to 17 year olds and a rising rate among 10 to 14 year olds. Contrasting birth rates among younger and older teens suggests a connection with the ability to control unplanned pregnancy. It seems that there is as yet no effective way of controlling unplanned pregnancy among the very young.

A look at the fertility rate of women in the teen and pre-teen population, which now numbers 20.1 million, reveals that 57 out of every 1,000 women 10 to 19 became pregnant in 1975. This means over one million pregnancies in that age group. One million pregnancies do not mean one million live births. In fact, more women 14 and younger received abortions than delivered living children in 1975.

Statistics alone do not offer a comprehensive view of the issues involved in adolescent sexuality and adolescent pregnancy. There is presently little data from the fields of education and social services to augment statistical information in the health area. Only sketchy information is available on the male partners of teen and pre-teen women who become pregnant or who are sexually active, and relatively little attention has been given to the economic and social consequences of early parenting for both young men and young women.

Public interest and concern for contemporary needs of pregnant adolescents and school-age parents as a special group is still fairly novel. Only in the late 1960s, through a movement to establish a multidisciplinary intervention approach, were pregnant adolescents and school-age parents singled out for attention because of their compelling need for a variety of human services.

By 1973 there were an estimated 250 special programs for pregnant adolescents and young parents. In its 1976 *National Directory of Services for School-Age Parents*, NACSAP lists information on 1,134 agencies providing some type of specialized assistance to young people who are pregnant, who are parents, or who are sexually active. The introduction to that publication indicates a constant state of change among persons and services listed, noting that such services are often considered "frills" rather than essential.

Early in 1977 NACSAP conducted a survey of agencies listed in the *Directory*, based on a stratified random sampling technique. These agencies include some that were reported to provide comprehensive services and also some that provided a single service such as health care, counseling, and/or education. Survey findings revealed that adolescent parents still have great need for infant day care services, direct financial assistance, housing arrangements, and parenting education. School-age parent services are rarely considered a priority but rather included in agency programs designed to meet the needs of other interest groups. Such services are vastly different from state to state and community to community, with piecemeal and inconsistent funding, involving a diverse array of agencies with vastly different approaches to the client population. At the federal level such services lack coordination on policy and funding authority.

Among the survey's conclusions: Without sustained follow-through intervention for a minimum of two years after birth, the long-term impact of such services on pregnant adolescents, young parents and their offspring is unpredictable. Primary prevention of school-age pregnancy will re-

quire considerable financial support from federal and state agencies.

A review of research literature from 1960 to 1970 by the University of Pittsburgh found that it generally viewed adolescent parents as social deviants and was heavily weighted with articles demonstrating size of the problem rather than evaluative research. Another survey of literature prior to 1976 conducted by the University of North Carolina questions whether the sexual behavior of adolescents can be charted on the basis of a few national studies with some built-in flaws. It also questions the methodology of research on which statements about health risks of adolescent pregnancy are based.

Recent research on cognitive theory reveals wide differences in timing of the shift from concrete operations, or ability to reason on the basis of objects which is characteristic of childhood, to formal operations, or ability to reason on the basis of abstractions or symbols which is more characteristic of adulthood. This change, even more variable at age of appearance than physical change, may begin in some persons at age eleven, in others not until the early twenties, and in some persons not at all. Such variability in cognitive structure has not been sufficiently studied. The part that adolescent cognitive development plays in teen and pre-teen sexual behavior could have vast implications for all phases of program development from sex education to the reasons for teens use or non-use of contraception.

Such questions are just beginning to be raised in research literature. These questions are also being asked by practitioners, but the two communities have not yet established mutual dialogue for determining an approach for testing such questions. In a small way NACSAP has attempted to bridge that gap through its research committee, but this effort must be augmented and expanded in order to achieve results.

Also important is the fact that service providers, historically, have not been active at policy-making levels. They have been recipients rather than initiators of policy changes affecting the youth population they serve. However, as the movement toward a multidisciplinary service approach has evolved, technical assistance has become a primary method of bringing about change in this field. In this context, NACSAP's emphasis has recently expanded into the area of policy development. As a membership organization representing those actively involved in serving pregnant adolescents, young parents, and sexually active youth, the Alliance, increasingly, has taken an advocate role and served as a link between those who initiate policy at federal, state, and local levels and those who carry it out at program levels.

Thus, NACSAP is hopeful that recommendations presented in this Report—based on issues highlighted in the summary—will have an influence on future policy development and dollar support for services for pregnant adolescents, young parents and their offspring, and sexually active youth.

A Profile of America's School-Age Parents and Sexually Active Youth

Some are *very* young	Pregnancy among 10 to 14 year olds is increasing.
Most are in their *mid-teens*	While birth rates for 18-19 year olds are declining, pregnancy among younger teens is increasing.
Many are *single* parents	Births to single mothers 15-19 increased by 63.8% from 1966 to 1975.
More *younger* women are having abortions	The typical woman receiving an abortion in 1975 was "young, white, and unmarried." More women 14 and younger had abortions than delivered children in 1975.
There is a *lack of consensus* among researchers about the health risks of adolescent pregnancy	Assertions that adolescents are a high-risk group are often based on secondary research which ignores factors such as race, socioeconomic status, and parity.
Risks of infant mortality are due to a *combination* of factors	Infant mortality rates for mothers under age 16 are higher than for older teens. However, the risks are greater when combined with lower socioeconomic status and poor prenatal care.
Significant *information gaps* exist about adolescent sexual behavior	Much demografic information is available about the incidence of adolescent pregnancy but there is little information on the complex behavior which causes teen and pre-teen pregnancy. For example, little is known about the male partner.
The *economic and social consequences* of adolescent pregnancy are generally unknown	While there has been much concentration on the medical and health risks of adolescent pregnancy, very little attention has been given to the economic and social consequences of early parenthood.
School-age parents and sexually active youth do not now have access to *age-appropriate* health and social services	While the educational rights of young parents are now more likely to be recognized, young parents and sexually active youth are still generally unaware that they have rights in the areas of health care and social services.
Teenage *unemployment* affects young parents hardest	Joblessness among teens—especially minority teens—is at an all-time high. The unemployed teenage parent has added expenses for child care and related responsibilities.
Racial differences among single parents are *narrowing*	In 1969 the birth rate for single black women 15-17 was about 11 times higher than the rate for single white women; by 1975 the differential was reduced to 8.
Teen and pre-teen parents are from *all* areas and backgrounds	There are teen and pre-teen parents living in suburban and rural areas as well as the inner city. They are from all ethnic and economic backgrounds.

SEX AND THE SUMMER TEEN: TIME OF TESTING

By Pat Lewis
Washington Star Staff Writer

Hanging out at Gino's, cruising in cars, drinking beer, smoking pot and partying eventually create a situation ripe for sex.

It is not fair to say that sex is rampant among Four Corners teens — they don't all have sex regularly. But it is fair to say that there are few virgins.

Kathy, age 14, and Butch, age 15, follow the formula for sex among the Four Corners set. They had been dating for four months. Kathy knew Butch's reputation: He had been having sex since the seventh grade. For four months, he hadn't even hinted to her about having sex.

"He's shy. He wanted to talk all the time. It was aggravating," Kathy says.

Kathy wondered whether she, a virgin, should have sex with Butch. "I thought about it all the time," says Kathy. "I didn't know what it was like. He's the right one if you know that if something happens — if you get pregnant — he won't leave you. You can tell if a guy really loves you."

WITH THAT CONFIDENCE, Kathy asked Butch about having sex with her. He said yes. She went to Planned Parenthood to get birth control pills.

A month later there was a party. They were drunk. The beer ran out at midnight. They were together until 2. Part of that time was spent in a bedroom.

"It just happened," says Kathy. "I was kind of scared. I felt stupid. I felt dumb. I felt like he took something away from me. I didn't like it. He doesn't mention it. It didn't change our relationship, but I shouldn't have done it."

Kathy stopped taking the pill after that, but is considering taking it again. "It might just happen," she says. "I'd like to be ready."

* * * *

"DEVIRGINIZATION," as they call it at Four Corners, occurs as early as 12 and 13, but usually by 16. The boy and girl have been seeing each other for several weeks, at least. And unless there is a steady relationship, there is little continued sexual activity.

Quite often, the first time, the youths are drunk with alcohol or high with marijuana. And quite often, it happens on a special occasion — prom night, the Fourth of July, a week at the beach, a party at someone's home.

The biggest deterrent is not the social taboo their parents knew as teens but the danger of pregnancy. Even so, birth control is lax. Often it is left up to the male, since some females are afraid of the pill and, among some, it is considered the sign of a "sleazy woman" (because she's always prepared) if she does not have a steady boyfriend.

Even though they are encountering their first sexual activity at a much younger age than generations before them, they still have little respect for those among them who are promiscuous and there is little talk about their own sexual activity, except to best friends.

They seem to consider sex similar to the first experiment with marijuana: something everyone is trying. And, like marijuana, they don't all like it.

* * * *

"AT 16 I WAS still a virgin," says a 17-year-old. "I wondered if there was something wrong. Everyone seems to know if you're a virgin and they respect you. I didn't have sex because of them. I had it because I wanted to know for myself.

"But I didn't have sex at all until I had been going with a guy for awhile. I thought about it for a long time. I wanted to, but I didn't want to. I didn't want to get pregnant.

"It was sort of an on-the-spot thing. He was good about it and didn't force me. I figured I might as well. If I'm going with somebody, I might as well not deprive him."

She didn't use any form of birth control for two months, after which she started taking the pill. She and her boyfriend had sex two or three times a week, in his house since he was 21 and lived alone.

"I was glad I did it, at last. I always wondered about it. I cared about him.

"When we broke up I started dating another guy. The only reason I had sex with him (six or seven times) was to see if I felt the same way about him. I didn't, so we broke up. I learned one thing: you should get to know him good before you go to bed with him. I still wish I hadn't had sex with the second one. Sex is all the same. The feelings behind it make the difference."

* * * *

NONE OF THE YOUTHS interviewed currently has what he or she considers a good sexual relationship. In fact, some don't like it.

"I don't have sex very often," says Charlene, 17. "Maybe once every six months. I don't want to. I don't like it a lot."

"I definitely felt bad the first time I had sex," says a 16-year-old, who has sex about once every two weeks, often in her own house when her parents are out. "It wasn't the right person. He beat me up. I don't know why. Sex is not important to me. If he can't like you for what you are, then he doesn't matter to me."

Floyd, 15, says he doesn't have sex as often now that his parents know he has it. "It's not as much fun as when my parents didn't know."

At 15, Linda remains a virgin. "If I fall in love and it happens, it happens. If I don't, I'll stay the way I am. I not afraid to have sex. I'd like to. But I'm not going to go ahead and do it just to find out what it's like. My day will come. I don't want to rush it."

THOUGH IT MAY SOUND old-fashioned in such a climate, the teens say there is respect for virgins. "Guys don't try to be fresh and make fools of themselves," says Linda.

"One guy told me that he respects a girl who is hard to get," said another girl, not a virgin.

"The guys tease girls sometimes," says one girl. "Once they called a girl 'Big V' — until she had a baby."

But there is not disrespect for girls who have sex. They are not "sleazy" — unless they tell everyone about it, or unless they are promiscuous. The girls are aware of guys who put the pressure on or are braggarts, and avoid them.

There is also respect for girls whether, after they get pregnant, they have an abortion or a baby. Youths at Four Corners say they have friends who have done both — and several who have married after getting pregnant.

The social question — is it wrong to have sex at 15? — isn't asked.

"There's nothing wrong with having sex," one says matter-of-factly.

"I don't know why they make such a big deal about it," says a 16-year-old. "There's nothing wrong with it. I don't see it at 13, but there's nothing wrong with it from 15 on up. Everybody does it."

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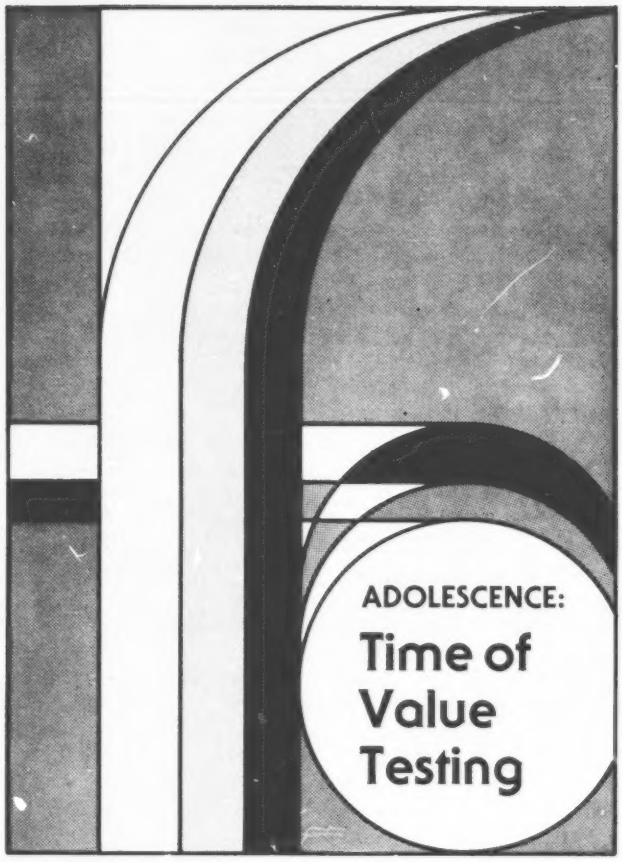

The views expressed in the foregoing article are confirmed in a special report on today's youth in the Fall 1977 issue of *Life* magazine.[1] The editors surveyed a large cross section of the country's young people, describing them as "tough, caring, wary, supercool, and practical."

The report features a series of interviews with freshmen at Wilde Lake High School in Columbia, Md., an economically and racially integrated community of 50,000 about midway between Baltimore and Washington. "The lives of these 14 and 15 year old freshmen have been mobile—most have moved at least three times—and often turbulent: as many as half live with only one parent. As yet unformed in all their values, still they seem relatively free of bigotry, buoyantly self-confident and open to all manner of experience," the report notes. Some of their comments on their own generation:

- "We're free. We're not like our parents because our parents always feel they *have* to do something, to act like they should. And I don't feel that way."
- "There's less and less pressure from society for doing what's right and what's wrong. It's more like what *you* think is right and what *you* think is wrong. You don't have to be so worried about what other people are going to say about you."
- "I think the main thing that adults are shocked about is how far we've gone with some things. "'My God, they're doing *that* already.'"

The views and life styles of these 14 and 15 year olds differ markedly from those of adolescents in the 1950's and earlier. In a recent article in *Children Today*[2], Mary Lystad, special assistant to the Director, Division of Special Mental Health Programs, National Institute of Mental Health, traces the changing image of adolescence in American books for children over the last 200 years. She describes the changes in role definitions and differing opportunities for adolescents as they are reflected in this literature. In the early years of our country the family, the church, the school, and the work place were the principal locations of activity for youth. Boys in particular spent much time with their fathers in an apprenticeship relationship. Girls were expected to practice gentility in the home or, like Goody Two Shoes, perform good works. Female docility was extolled.

The books fo the 20th Century place less stress on future roles, the author points out. "Rather, the adolescent's present feelings and values are explored. Negative feelings are seen as sometimes appropriate and certainly normal. Values are seen as relative rather than absolute." The modern world offers more choice of lifestyle, career, family structure, artistic expression, Lystad explains. Adolescence is acknowledged as a legitimate growth period. However, the author observes that present role models are more available to young men than to young women and to young whites than to the young of several minorities. "The white models are more adventuresome, and they more often start out with stable economic and social situations. The careers of minority models usually involve struggle and oppression."

Psychiatrist William Glasser, commenting in a special issue of the *Instructor*[3] developed around the theme "Are Today's Kids Different Than Yesterday's", observes:

"Yesterday's child was goal motivated, today's child is role motivated. This means that yesterday's child responded to fear and to power and felt if he didn't do the things he ought to do, he might not survive in a goal-oriented society. Today's child raised in affluent, television-interested society is assured of survival and is looking for things to further his belief about himself as a human being."

Reverend Jesse Jackson,[4] also interviewed, comments:

"This generation faces, as no other generation before, a communications explosion. Historically the home, religious institutions, and schools have been the primary social agents. The home provided security and identity, religious institutions transmitted moral values, and the school passed along information. Today, radio and TV have supplanted them, becoming the major tone setters, value orienters, and educators."

Self Doubt and Peer Pressures

Even though today's generation of youth seems to be more inner-directed and self-assured this is not to say that they are a super race of adolescents who never suffer the self doubts, peer pressures, or values testing encountered by previous generations.

James S. Gordon, research psychiatrist and consultant to

the National Institutes of Mental Health, recently spent 18 months as a participant-observer in meetings of the new religious cults of the 1970's. In an article in *Children Today*[5] he explains the search for values that has turned many of today's youth in the direction of exotic new religions: "Young people often do come to these religious groups during a period of heightened uncertainty, in a period of life characterized by anxiety about career, sexuality, intimacy, and the 'meaning of life.' But this uncertainty is a product of our society and an integral part of the extended period of youth that we in the industrialized West offer to people in their late teens and twenties."

Gordon sees parental and public opposition to the cults as myopic and cautions against over emphasis on the dependency role of youth, calling them "boys and girls" and continually speaking of parental rights. He notes that "removing an unwilling young person from a cult is sometimes a move (by an adult) in a continuing battle for control of that person's life."

Understanding the importance of autonomy in the life of today's adolescent is key. It is an especially important factor in the area of sexuality. This was brought out at the 1976 NACSAP national conference in a small group session on decision-making when several youth delegates agreed that one of the few times they have genuine control is when they make a decision for or against contraception.

They also acknowledged that peer pressure is a strong factor influencing sexual activity. The fact that "older girls are doing it" becomes an incentive, a way for the younger teens to show that they are grown up and the equals of their older sisters.

The pressure is equally strong on young men. In a society where they are most frequently jobless and in a state of dependency, sexual experimentation is one of the few ways they have to prove their manhood.

Different levels of autonomy and personal control are involved for differing adolescent age groups faced with decision making about sexuality. In the early teens there is anxiety about being a virgin and the personal decision about where, when, and with whom to "lose it." As many of the young people quoted in the opening story found, the experience was not always what they had expected. In fact, few of those interviewed had what they considered a good sexual relationship.

In a series of interviews with young, single pregnant adolescents at a metropolitan hospital, W. Godfrey Cobliner[6] found great peer pressure for early sexual experimentation and a genuine longing for intimacy. However, he explains: "The partner was certainly not chosen because he was a friend; one did not share confidential matters with him, for example about sexual unfulfillment, nor did he become a friend when sexual intimacy endured for an extended period. At the same time, the girls, with very few exceptions, had no one of the same or opposite sex in whom they could confide, even though they wished they could find such a person. The session records conveyed the strong impression that sexual intimacy was a casual 'operation,' hardly an experience, but rather a by-product or the price of keeping company with a boy. The partner was, psychologically speaking, just a technical cause of the unintended pregnancy." On the other hand some research shows that this generation of young men and women communicate more openly with each other and that there is more real friendship and sharing among the sexes than before.[7]

Taking Responsibility

One of the reasons, according to some researchers, for the declining birth rate among older adolescents—the 18 and 19 year olds—is that they are beginning to have some personal control over their sexuality. By that age, if a young woman is sexually active she has made a decision about contraception, has learned the method that is right for her and is using it regularly.

There is also the phenomenon of "revirginization" among this age group. Young women who have engaged in sexual activity and have found that they did not like it, or that it was not "worth the hassle," decide that they will no longer be sexually active. The problem is that such decisions are never simple. As in all human relationships, and especially in sexual relationships, there is a vast gray area subject to change, chance, and circumstance.

As the introductory interview with teens indicates, a young woman who does not have a steady boyfriend is considered "sleazy" if she plans for sexual activity. Anticipating sexual behavior requires admission and acceptance of responsibility. The research section of this paper presents findings relating to teen and pre-teen cognitive development indicating great levels of variance which could affect the ability to accept such responsibility.

According to some psychologists, contraceptive behavior does not always conform to rational, externally voiced attitudes and conflicted psychological forces, conscious and unconscious, are extremely influential.[8] Any individual who is reluctant to accept responsibility in other spheres of life will tend to avoid it in sexual and contraceptive matters as well.[9]

The recent report by the National Center for Health Statistics, *Teenage Childbearing: United States, 1966-1975,*[10] shows a striking difference between the birth rate for young women 15 to 17 and those between 18 and 19. In the 15-17 age group the birth rate was 36.6 births per 1,000 in 1975, with little variation over the previous 9 years. By contrast, the birth rate for 18-19 year olds show a steady and substantial decline, from 121.2 in 1966 to 85.7 in 1975. This is a 29.3 percent decline, nearly the same as the 26.9 percent decline in the general fertility rate.

The contrast in birth rates among younger and older teens suggests a connection with the ability to control unplanned pregnancy. It also suggests that an effective mechanism for birth control among the younger teens has not as yet been devised.

Influences on Decision-Making

There are a multitude of factors that influence not only adolescent sexual behavior but the outcome of adolescent pregnancy. In the early stages, before the young woman has made up her mind about the options of abortion, adoption, or keeping the infant, the solution she chooses often depends on who she talks to first.

Researchers have speculated that if a number of pregnant teens were randomly assigned, some to an abortion clinic, some to an adoption agency, their choices of a solution would be vastly different.

Family attitude about the pregnancy is one of the most important influences on the solution. If the parents are supportive, the young woman has a better chance of keeping her child, living at home and continuing her education. A lot of teens want to live at home with their baby and their parents want them there, but in order to become eligible for welfare, they are forced to leave home.

What are the implications for the community in such a situation? If the inclination is to support and protect the family structure, how can the extended family be strengthened and used as a resource in such cases? What is it that makes the difference between a family that rejects the pregnancy and one that accepts it? What does this mean to the young mother in terms of material and psychological help? When resources are deployed to the young mother, what does this mean to the whole family? What about the father? How is he accepted? How does early childbearing affect the kinship network? What are the long-term consequences of early childbearing?

These are just a few of the questions that come up around the issue of the family's role. There are many others that occur at every level of decision-making about adolescent sexuality and childbearing. They are brought out in other sections of this report.

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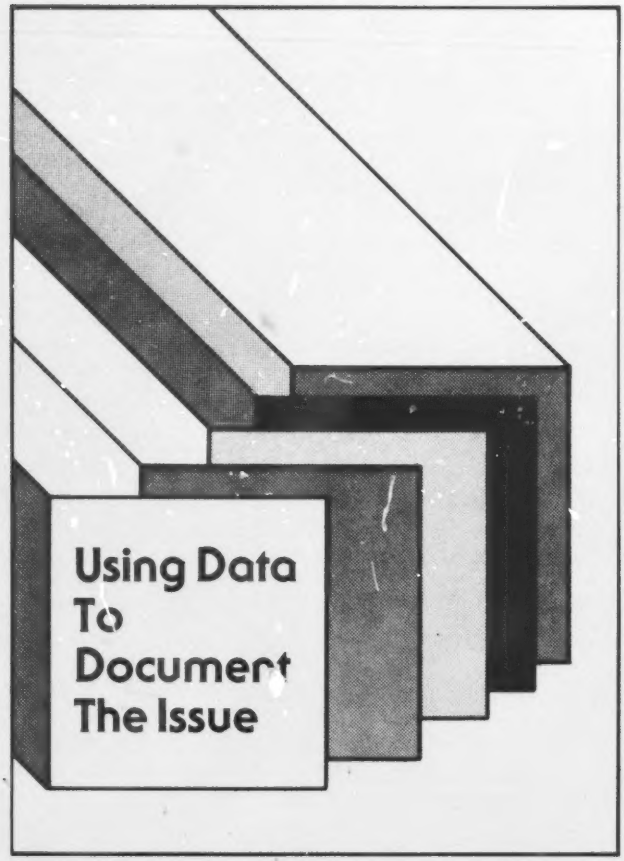

Recently the word "epidemic" has been frequently linked with teenage pregnancy. To a large extent the use of this word can be traced to wide dissemination of *11 Million Teenagers, What Can Be Done About the Epidemic of Adolescent Pregnancies in the United States* published in 1976 by The Alan Guttmacher Institute.[1] The word "epidemic" has been picked up by the media and by individuals and organizations as a kind of shorthand phrase which immediately conjures up an alarming picture of a rapidly spreading disease.

One of the purposes of this paper is to analyze the accuracy of that portrayal, or any portrayal of adolescent pregnancy, to look critically at the available statistical and socioeconomic data and their implications for research, services, and policy.

Persons looking for information in this field are likely to become confused by the variety of statistics available on adolescent fertility rates and birth patterns. Numerous groups have been interested in specific aspects of adolescent pregnancy and have published materials written from their particular focus. For example, population groups have issued pamphlets documenting the population-related aspects of adolescent pregnancy; the National Foundation-March of Dimes has published material on the health aspects, with emphasis on nutrition and prenatal care; and publications of groups such as the Parent-Teachers Association and Future Homemakers of America have focused on the parenting aspects. Family planning agencies and groups have long been concerned about the issue and have published numerous reports on the dangers and risks of early childbearing.

It is relatively easy to obtain information on how many teenage women have given birth. The National Center for Health Statistics (NCHS) keeps an accurate record of such information supplied through birth certificates issued by 23 reporting states and data from the remaining states based on a 50 percent sample. It is also possible to obtain national and state statistics on infant mortality and morbidity. All of this information is useful in piecing together a statistical profile of young parents and their children.

However, until recently, births to all women under 19 have been lumped together. It was not possible, for example, to obtain age-specific information on births to women under 15 and consequently it has been difficult to make age cohort comparisons. Moreover, what is not available is information on what happens to these young parents and their children after the birth. A system for documenting the long-term consequences—the ecological effect—of teenage childbearing is not yet in place.

The following facts, documented from primary sources, help to illuminate and illustrate the issue.

Comparative Natality Statistics

There has been an actual decline in the teenage birth rate but the great number of young women who are now of childbearing age cancels out the implications of that decline.

- In 1957—at the height of the last baby boom—the birth rate was 96.1 per 1,000 women 15 to 19. In 1975, it was 56.3 per 1,000 women 15 to 19.[2]

However, it does not necessarily follow that a *decrease* in the birth rate automatically means a *decline* in the number of births for that particular age group. It depends on the number of persons in that age group.

- In 1957 there were 13.1 million females of childbearing age (10 to 19). The total number of births for that age group was 557,172.[3]
- In 1975, the number of females 10 to 19 nearly doubled—20.3 million—and the number of births to women of that age group increased to 594,880.[4]

Looking at these figures on an age-specific basis shows that births to females 10 to 14 has nearly doubled.

- In 1957 there were 6,960 births to females 10 to 14.
- In 1975 there were 12,642 births to that age group.[5]

A September 1977 NCHS report on Teenage Childbearing[6] shows some striking differences over the period 1966 to 1975 in the birth rates of young women 15 to 17 and 18 to 19. Although the number of births in 1975 declined from the total in 1966, the decline resulted entirely from an 18.3 percent *reduction* in the number of births to *older teens*—18-19 year olds. Births to *younger teens*—15-17 year olds—*increased* in this period by 21.7 percent.

Looking at births to these age groups by race reveals other important differences.

- Births to white women 15 to 17 increased 6.4 percent between 1966 and 1975.
- Births to black women 15 to 17 showed an 11.5 percent decline in that period.
- Births to both white and black women 18 to 19 years old declined during 1966 and 1975, with the race differential increasing only slightly.

There is no detailed discussion of childbearing among the 10 to 14 age group. The report explains that the rates and numbers in that age group are "so small, they do not support the more detailed analysis" given for the 15 to 19 year olds. However, an earlier report[7] shows that there was an 8 percent increase in births to 10 to 14 year olds from 1974 to 1975.

Overall, then, there seems to be a seesaw effect in the births to the 10 to 19 age group. The steady and substantial decline in the births to 18 and 19 year olds is offset by the relatively unchanged rate among the 15 to 17 year olds and the rise among the 10 to 14 year olds. These differences have significant implications in the areas of services and research which are treated in other sections of this paper.

Births to Single Women by Age and Race

In 1975 an estimated 222,500 infants were born to unmarried females 15-19 years old.[8] This represents a sharp increase in births to single women of that age group over the last 10 years. In 1966 an estimated 135,800 babies were born to single mothers 15-19 years old.

Thus, while *total births* to mothers 15-19 years *declined 6.3 percent* from 1966 to 1975, *births to single mothers* in that age group *increased by 63.8 percent.*

A further breakdown of that figure shows that births to single women 15-17 rose 77.2 percent, while the increase for single women 18-19 measured 51.6 percent.

Looking at births to single teenage women by race the figures reveal a *narrowing trend* for the 15-17 age group between 1969 and 1975. This was true principally because of the *greater increase* in the rate for *white women.*

In 1969 the rate for single black women 15-17 was about 11 times higher than the rate for single white women; by 1975 the differential had been reduced to 8. The race differential in the rates for women 18-19 years old fluctuated between 7 and 9 for all years.

Part of the increase in single parenthood is due to the number of young women in those age groups who were born at the peak birth years of the 1950's and early 1960's. Another reason for the increase of births to single women in that age group is the declining marriage rate for teenagers in recent years.[9]

Educational Attainment

Age was the critical factor determining the likelihood that a teenage mother would have at least a high school education. According to data from 33 states and the District of Columbia,[10] young mothers were much less likely to have completed high school than were mothers in their twenties. Of the 17 year olds giving birth in 1975, only 16.3 percent had completed high school compared with 59.1 percent of 19 year old mothers.

Incidence of Low Birth Weight Infants

Infants born weighing 2,500 grams or less (5 pounds 8 ounces or less) have higher rates of infant mortality, mental retardation and birth defects.[11] Babies born to teenage mothers are more likely to be of low birth weight than are infants born to mothers in their twenties, and the incidence of low birth weight is higher as age of mother declines among teenagers.

Thus *in 1975, 13.0 percent of births to mothers 15 years old weighed 2,500 grams or less* compared with 9.0 percent for births to 19 year old mothers. The proportion of low-weight infants declined even further for births to women aged 20-24 years and 6.1 percent for births to women aged 25-29. This association of age of mother and low birth weight is seen regardless of race or marital status.

Incidence of Inadequate or No Prenatal Care

Young teenage mothers are much more likely to seek prenatal care relatively late in their pregnancies or to have no prenatal care at all.[12] For example, the proportion of 15-year-old mothers beginning prenatal care in the seventh to ninth month of pregnancy was almost twice the comparable proportion for 19-year-old mothers and almost 5 times the proportion for mothers 25-29.

Similarly the younger the mother, the less likely she was to have begun prenatal care in the critical first trimester of pregnancy. Among 15-year-old mothers, only 39.7 percent began prenatal care in the first three months of pregnancy. These relationships between age of mother and onset of prenatal care hold regardless of race. White mothers of all ages, however, began care earlier on the average than did black mothers.

How Statistics Are Interpreted

If you look at the fertility rate of women in the current teen and pre-teen population, which numbers 20.1 million, you learn that 57 out of every 1,000 women 10 to 19 became pregnant in 1975. This means over one million pregnancies in that age group. *One million pregnancies do not mean one million live births.*

No one has a good estimate of the number of abortions, miscarriages, and stillbirths to women in this age group. The primary information source is the Public Health Service's Center for Disease Control (CDC). Its latest report, *Abortion Surveillance, 1975*,[13] notes the problem of underreporting. The study further points out: "An estimate of the magnitude of underreporting can be made by comparing the total number of abortions reported to CDC with the total obtained through the Alan Guttmacher Institute's nationwide survey of abortion facilities. For 1975, CDC's total was approximately 15 percent lower than AGI's, as was true in 1974."

The CDC summary profiles the woman obtaining a legal abortion as "young, white, and unmarried." In 1975, according to the report, one third of the women receiving abortions were in their teenage years, and *"more women 14 and younger received abortions than delivered living children in 1975* (1,193 abortions per 1,000 live births.)" One example of the latest statistics in local reporting: The District of Columbia's Department of Human Resources recorded that 27.2 percent

of all abortions in 1976 were to the 15 to 19 year old group. At the same time, the percentage of children born to mothers under 20 decreased for the first time since 1970.

The Anonymous Male Partner

There is very little information available on the male partners of the teen and pre-teen young women who become pregnant or who are sexually active. Data from the National Center for Health Statistics indicate that the majority of the fathers of babies born to women under 15 are teenagers, and the fathers of babies born to women 15 to 19 are in their teens or early twenties. Melvin Zelnik and John F. Kantner, in their study, "Sexual and Contraceptive Experiences of Young Unmarried Women in the United States, 1976 and 1971,"[14] note that the male partner at first intercourse is generally two to three years older than the female. More than 85 percent of the first partners of black teenage females are themselves teenagers; for whites the figure is 73 percent. But they also point out that the male partner in subsequent intercourse is older. More than half the most recent partners, regardless of race, are 20 years of age or older. This high proportion of older males is due in part to the predominance of 18 and 19 year old females among the sexually experienced.

While this information on males is useful, it is impossible to generalize or draw any conclusions, other than age, about the male partners of teen and pre-teen women from the Kantner and Zelnik survey since the study did not actually include males but was based on information supplied by randomly selected females. Among the very few studies that did include males is Robert C. Sorenson's 1973 report on *Adolescent Sexuality in Contemporary America*.[15] However, the entire sample consisted of only 411, half of whom were males.

In his six-year study (1966-1970) of 404 Baltimore adolescent mothers and 301 of their classmates who did not become pregnant,[16] Frank F. Furstenberg sought to contact 260 of the fathers. Interviewers managed to find only slightly more than half of these men and complete interviews with only 33 percent of that number. In his report, "The Social Consequences of Teenage Parenthood," Furstenberg notes that most of the males interviewed were sexually active by age 14 and had more frequent and more varied sexual experiences than the females. He added, "It is not surprising, then, that when the pregnant teenagers were asked why a female begins to have sexual relations, the most common response was inability to successfully resist pressure from the male." Furstenberg points out that 31 percent of the women who were 15 or younger at conception ultimately married the father of the child, compared to 53 percent of the 17-year-olds. The boyfriends of the younger women often were school dropouts and were less likely to find steady jobs than the other fathers.

Premarital pregnancy was not a covert tactic used by teenage mothers to bring about marriage, Furstenberg explains. Most of them indicated they would have chosen to marry at a later age under normal circumstances. When comparing the adolescent mothers with their classmates who did not become pregnant, the study found that the young mothers consistently experienced greater difficulty in realizing their life goals.

Socioeconomic Indicators

While there has been much concentration on the medical and health risks of adolescent pregnancy, very little attention has been given to the economic and social consequences of early childbearing. The Furstenberg study, admittedly limited, was originally designed to explore the sexual patterns and attitudes toward birth control of the pregnant adolescent who registered for prenatal care at a Baltimore clinic.

In a 1975 paper on the economic consequences of teenage childbearing,[17] T. James Trussell points out that no study of female participation in the labor force has included age as a dependent variable. He recommended further study of the effect of early childbearing on wage rates, labor force participation, education, and later economic position. He noted that not only does adolescent pregnancy have a depressing effect on the socioeconomic future of young women but it can also affect young men—married or unmarried—who take on early family responsibilities. They are often forced to take work which offers less on-the-job training, thus limiting their future chances for advancement. Their opportunity to search for higher paying jobs may also be curtailed by child-care responsibilities. He points out that the effect of early childbearing on the husband and father has not been sufficiently analyzed but cites a Detroit study,[18] showing that husbands of premaritally pregnant wives had markedly fewer years of schooling and were only one third as likely as other husbands to have finished college.

Harriet B. Presser, in her 1975 paper on the "Social Consequences of Teenage Childbearing,"[19] observes that there is remarkable consensus that adolescent pregnancy constitutes a serious social problem but "surprisingly little empirical evidence to justify that position." She points out that most of the research on teenage parenthood is concerned with illegitimacy, although "teenagers who choose to marry rather than have an illegitimate child (or abortion) may experience negative social consequences as well."

Presser studied a group of 408 New York women who had first births in 1970-72. She found that a first birth at a relatively young age had a restricting effect on the role achievements of the women studied. Only 23 of those who said they were planning to go back to work within a year were, in fact, employed a the time of the second interview. The younger the woman at first birth, the less likely she was to realize this aspiration, the study showed. It also revealed that the women who had an early first birth were the most likely not to have graduated from high school. Fully half of these teen mothers said they wished they could have postponed their first pregnancy; 81 percent of the pregnancies were unplanned.

Young Parents in the Work Force

In an August 1977 study of youth unemployment,[20] the Bureau of Labor Statistics found that while there was considerable improvement in the number of white teenagers with jobs, the number of black youths—particularly black males—unemployed rose by 100,000 to a rate of 34.8 percent.

"This is not a new problem," commented Labor Secretary Ray Marshall at a press conference. "The shortage of job opportunities for teenagers and young adults has persisted in this country for years. But with a teenage unemployment

rate that has hovered around 18 percent for more than a year and a jobless rate for minority youths that approaches 40 percent, the problem of finding meaningful jobs for these workers has now become critical."

The Labor Secretary said he will be announcing several new programs in the coming months to deal with the youth unemployment situation. One federal program designed to serve needy youth provides funds for the Comprehensive Employment and Training Act (CETA), through federal revenue sharing legislation. Besides providing jobs, the CETA program also helps younger workers to gain much needed experience. Job training has been a problem for teenagers since their status as minors often makes them ineligible for training programs that lead to more desirable jobs. State licensing restrictions may present other obstacles as do some jobs requiring union membership.

In addition to the limitations placed on the average teenager who wants to enter the job market, the teenager who is a parent carries responsibility for child care and concern about additional unplanned pregnancies. Even if young parents come from a background of affluence, it is difficult for them to assume full financial responsibility since their status as minors places them in a position of dependency. Because they have not usually completed their schooling they are not free to set up their own households or to take full responsibility for childrearing.

Young Parents: who are they; where do they live?

Teen and pre-teen births are not confined to any one population area. They occur among young people of all ethnic and economic backgrounds. There are teenage and pre-teen parents living in suburban and rural areas as well as the inner city. The number of births to teens and pre-teens in non-metropolitan counties, those with populations below 50,000, showed the same one out of five ratio to all births in 1975.[21]

Looking at births to young women under 19 on a regional basis, the South and Southwest rank highest with 20 percent or more of all births in this age group. Mississippi is the highest, with 28.2 percent; the District of Columbia ranks next with 26.8 percent. In other areas, Indiana and Missouri had percentages higher than the national average. Utah ranked considerably lower, as did Massachusetts, Connecticut, and Minnesota. Both Maine and Louisiana showed increases in the proportion of births to teenagers, while South Dakota, Nevada, and Oregon reported decreases. States with over 500 births to females under 15 were: California, 866; Florida, 815; Georgia, 662; Illinois, 760; Mississippi, 503; New York, 656; North Carolina, 511; Ohio, 616, and Texas, 1,056.[22]

Toward a Comprehensive View

On the basis of the information outlined above, it is difficult to characterize teenage pregnancy as an "epidemic." We have seen that in terms of absolute numbers adolescent pregnancies have not shown an alarming increase over the years. In fact, in light of the great increase in the adolescent population, the number of pregnancies has held surprisingly steady. However, by virtue of the fact that the highest rates are now showing up among the very young, there can be no doubt that the issue is critical. The dilemma is that mere statistics do not offer a comprehensive view of what is happening to young people as they attempt to deal with their own sexuality. While the public health aspects of the issue are fairly well documented, the long-term implications for sociology, education, the job market, and other areas of interpersonal and intergenerational relations remain uncharted.

Answers to the following questions could provide a framework for an information system that would begin to give a more accurate and refined reading of the consequences as well as the dimensions of teen and pre-teen childbearing and sexual activity.

1. How can statistical and socioeconomic data be used to draw a comprehensive picture of the needs of young parents and sexually active youth?
2. Since reporting systems are not universal among the states, how can we work to involve all states in a consistent reporting network?
3. What adjustments can be made in the existing system to more accurately reflect the adolescent birth rate and its consequences for individuals and society?
4. Since the only information presently available is statistical, how can we encourage responsible use of such data?
5. Since we are presently without a reporting system in education and social services that would augument statistical data in the health area, how can such a system be developed?

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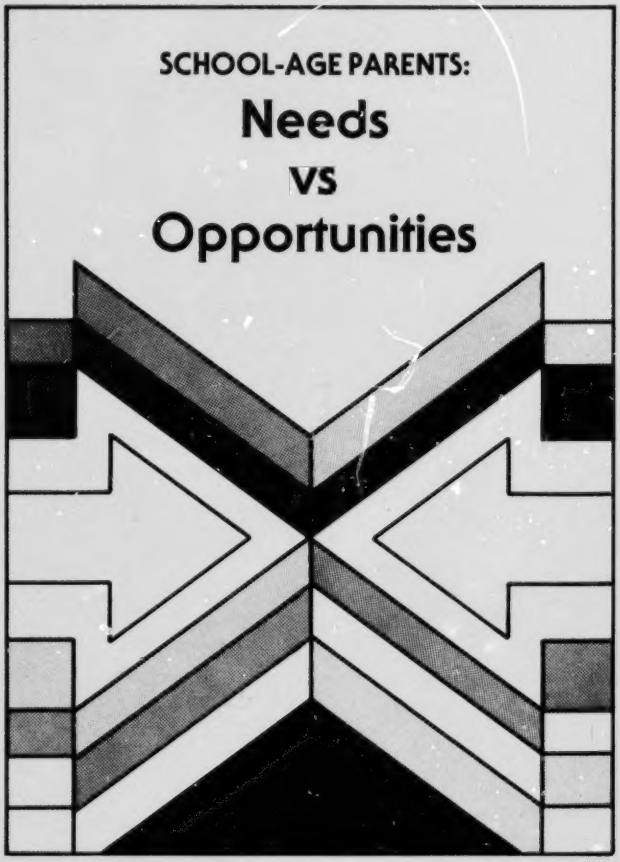

Young persons who become parents are not only penalized economically and socially but the opportunity to continue their education is very often curtailed. This in turn short circuits their future earning and learning ability. If the couple marries, the father is usually compelled to drop out of school or cut short his time in classes in favor of a job to support his family. If he is not married but known to school authorities, he is often barred from participating in extracurricular activities, including team sports. For young women, married or single, the penalty is more severe. It often means the end of formal education.

In 1970 few states had specific laws dealing with the education of pregnant students, whether married or single. Traditionally, this was viewed as a local matter, i.e., the local school board or principal could decide whether pregnant students were allowed to remain in school, receive homebound instruction, or attend classes. In many cases it was assumed that the young woman would drop out of school as soon as her pregnancy began to show; she was often considered a bad example to the other students. Homebound instruction, the solution of many school districts, was a poor excuse for regular school, with a few hours a week tutoring from a visiting teacher. Adult education, another solution, was usually inappropriate, with classes at inconvenient hours and the student often ineligible because she was under age.

Few young parents, even in the early 1970's, were aware that they do, indeed, have a right to an education and even fewer were able to articulate it. If they were given an opportunity to continue their education during pregnancy, it was often because of the intervention of a concerned adult such as a school nurse, or a guidance counselor, who learned of their case and acted as a go-between with school authorities. Sometimes pregnant students were included in classes for the handicapped. Often the concerned adult was a homebound teacher who knew a number of pregnant students and was able to convince the principal or the school board that it would be cheaper to teach these young women in special classes.

Thus, special classes began to appear in a few school districts around the country but generally the education of pregnant students was neglected simply because most local school districts expected young women to drop out of school without protest. The situation was similar to many welfare programs or the food stamp program where a majority of those eligible were not expected to apply for benefits. However, with the civil rights movement, social activists taught the disenfranchised that they do have rights and they can and should make demands on society.

A series of court cases began to test and affirm the educational rights of pregnant students. In 1969 the NAACP Legal Defense and Education Fund argued in Perry vs. Grenada (Mississippi) Municipal Separate School District[1] that two young women who were single parents could not be denied their legal right to a public school education. The school board had taken the view that they were a threat to the manners and morals of the other students. The U.S. District Court judge ordered the school board to allow the young mothers to return to school.

In 1971 the U.S. District Court of Massachusetts ordered the North Middlesex Regional School District[2] to restore the right of Fay Ordway, an unmarried pregnant student, to attend high school during regular school hours. The school had offered her after-school and tutorial assistance but an educational expert testifying for the plaintiff stated that these services could not be considered the equivalent of the education offered her classmates in regular school.

In 1972 then U.S. Commissioner of Education, Sidney P. Marland, Jr., issued a statement urging all U.S. school systems to provide continuing education for all pregnant students.[3]

"Every girl in the United States has a right to and a need for the education that will help her to prepare herself for a career, for family life, and for citizenship. To be married or pregnant is not sufficient cause to deprive her of an education and the opportunity to become a contributing member of society."

Read in light of the later Title IX of the Education Amendments Act forbidding sex discrimination against students and employees in federally assisted education programs, the Marland statement appears to lack toughness. It carries no threat to withhold federal funding for noncompliance. However, at that time, the Marland statement was a breakthrough, especially for practitioners working to provide services for

pregnant students. It put the prestige of the U.S. Office of Education behind the drive to assure the educational rights of pregnant students, stressing that "most pregnant girls are physically able to remain in their classes during most of their pregnancy."

How did this actually work? The court cases had established some precedents and school boards were beginning to acknowledge the educational rights of pregnant students. In 1973 a legal memorandum issued by the National Association of Secondary School Principals[4] noted the following guidelines emerging as the result of court decisions:

- "The right to an education is a fundamental property right not to be denied unless an overriding public interest is served.
- "Marriage is not sufficient grounds for exclusion of a student from regular academic or extracurricular activities.
- "Pregnancy, whether the girl is married or unmarried, does not appear to be sufficient grounds for exclusion from regular academic curriculum and probably even extracurricular activities."

In 1976 Congress passed Title IX prohibiting sex discrimination in any academic, extracurricular, research, occupational, or other education program operated by an organization which receives federal aid. Section 86-40 of this regulation states that a school may not discriminate against any student in its educational program, including any class or extracurricular activity because of the student's pregnancy, childbirth, false pregnancy, miscarriage, or termination of pregnancy, unless the student voluntarily requests to participate in a different program or activity. If a school does offer a voluntary, separate education program for pregnant students, it must be comparable to the school's regular instructional program.

Comprehensive Services—Unfilled Needs

While the educational rights of young parents are now more likely to be recognized, their right to age-appropriate health services and social services, as needed, are still emerging and deeply affected by societal attitudes. Indeed, young parents and sexually active youth are still generally silent and unaware that they have rights in these areas.

The Marland statement suggested that "local school systems have an obligation to cooperate with such other state, county, and city agencies as health and welfare departments and with private agencies and physicians . . ." to assure the establishment of comprehensive service programs for school-age parents. However, this "obligation," has generally been deemphasized at state and local levels.

Writing about the development of the movement to provide comprehensive services for young parents,[5] Marion Howard, former director of the Consortium on Early Childbearing and Childrearing, notes that it converged with several other important forces for social change which evolved during the 1960's, including the civil rights movement, the women's movement, consumerism, concern about population growth and day care services, along with technological advances in birth control.

However, public concern alone is not always sufficient to bring about change. The involvement of the federal government in the area of school-age parent services turned out to be the crucial factor and, from some perspectives, both an enabler and later a deterrent. To some degree, Howard notes, the federal interest ran parallel to, but was quite different from the ground swell for social change. Among the federal concerns were: a high U.S. infant mortality rate concentrated among women of very young age; public pressure to do something about the large welfare burden, particularly as it was connected with illegitimacy; and information showing that pregnancy was the major known cause of school dropouts among young women.

Among the efforts to impact on these areas of federal concern was the establishment of a research and demonstration program to provide comprehensive health, education, and social services. The Webster School in the District of Columbia was granted funds for this purpose from the Children's Bureau (DHEW) under the Maternal and Child Health and Crippled Children's Services research grants program. When the results of this program proved encouraging, The Children's Bureau granted additional funding for an effort to share the information gained through the District of Columbia experience with other communities struggling with similar problems.

A consortium, with research contributions from Yale University, the University of Pittsburgh, and George Washington University, was developed to promote comprehensive service programs for pregnant adolescents and school-age parents. Based in Washington, D.C., this project was first known as the Cyesis Programs Consortium and later as the Consortium on Early Childbearing and Childrearing. Its focus was research utilization and information sharing among those concerned with the problems of adolescent childbearing. Initially, the project concentrated on practitioners already involved in programs for school-age parents, providing them with information on model programs and recent research findings. Later the project was enlarged to include a wider range of community leaders and service providers in an effort to gain interest and support for the movement for comprehensive services and to remove inhibiting restrictions such as school attendance by pregnant adolescents.

Simultaneously, some service providers were expressing interest in the development of an advocacy movement that would not be exclusively dependent on federal support. To a great extent this interest resulted from a reluctance to rely on a single source of dollar support which could inhibit future development. This was, in fact, the status in which the Consortium found itself from its inception. Thus, those who were involved in shaping the Consoritum also recognized the need for an advocacy movement, with a membership organization as an appropriate means for bringing together professionals and other interest groups through a national network.

As perceived in 1969 by its founders, the National Alliance Concerned with School-Age Parents (NACSAP) was an organization that would provide technical assistance to those working with pregnant adolescents and school-age parents. It was also agreed that NACSAP would develop strategies for preventing high-risk adolescent pregnancy. NACSAP's initial membership consisted mainly of those whose professional careers were uniquely concerned with the provision of services to pregnant adolescents. They included physicians and allied health professionals, social workers, teachers, school administrators, and researchers.

Dollar support for the Alliance came initially from the federal government, specifically, the Maternal and Child Health Service, which awarded NACSAP a three-year contract to conduct conferences and follow-through plans in several different states.

The movement gained momentum in 1971 when Elliot L. Richardson, then Secretary of Health, Education, and Welfare, signed an Action Memorandum approving an enlarged information dissemination and technical assistance effort aimed at promoting the extension of comprehensive services to all school-age parents. At the same time the Secretary appointed a federal Inter-Agency Task Force on Comprehensive Programs for School-Age Parents in the U.S. Office of Education, to work within DHEW to promote and coordinate the federal effort.

This entailed a series of statewide conferences sponsored by the Consortium and NACSAP. Their objective was to heighten public awareness of the needs of young parents and to bring together leaders in the fields of health, education, and social services to establish action plans at state and local levels. Through the multidisciplinary approach of these statewide conferences, concerned practitioners began to share information with each other, often for the first time.

One of the aims of these conferences was to develop a paying membership base which eventually would replace income from the federal government. This was not achieved during the first three years of NACSAP's initial development. While there was interest on the part of a few people, it was not easy to convince prospective members that a national membership association focused on the needs of pregnant adolescents and school-age parents could offer services that would be especially helpful to them in their local communities. In effect, the technical assistance program had not been sufficiently defined before initial efforts were made to promote such a concept.

As of 1977, the wide range of technical assistance strategies available (see pp. 23-25) to existing and prospective members reflects the level of development of school-age parent programs and the growth of NACSAP as an organization. However, despite the fact that NACSAP's technical assistance program has now been defined and the organization has nearly 2,000 members, the Alliance has not been able to realize its full potential for impacting on the prevention of high-risk adolescent pregnancy. One of the difficulties has been that a major source of NACSAP's funding has always been related to carrying out a special project. Since NACSAP is now the only group with a multidisciplinary approach to this issue, more than ever, it has a major need for support for organizational development. Until and unless such support is realized, the strength of the technical assistance program now in place will be jeopardized.

The compelling need for such an effort has never been greater (see program evaluation, pp. 19-22). Even though there were an estimated 250 comprehensive programs serving pregnant adolescents by 1973, the quality of some of these programs was questionable. In its 1976 *National Directory of Services for School-Age Parents*, NACSAP lists information on 1,134 agencies providing some type of specialized assistance to young people who are pregnant, who are already parents, or who are sexually active. However, the introduction to the *Directory* points out the constant state of change among persons and services listed, noting that support services for young people who become pregnant and/or parents are often considered "frills" rather than essential components of programs. A random sample survey of such programs conducted by NACSAP early in 1977 showed that few offered infant day care or interconceptional services, including birth control, and still fewer offered services for males. Counseling about options such as adoption or abortion was also limited. Programs generally developed services around the chosen pregnancy solution. The majority of young women opted to keep their infants.

Birth Control Services to Minors Limited

By 1976, 31 of the 50 states had affirmed the right of minors to obtain pregnancy related care and 27 states allow minors to consent to contraceptive services without parental permission.[6]

Although a more open and accepting view of premarital sexual behavior is developing in America, vestigages of the puritanical past persist, Frank Furstenberg observes in his study of the Social Consequences of Teenage Parenthood.[7] He decribes the "timidity of the approach toward prevention" and the hesitancy of family planners to reach out aggressively to involve the teen and pre-teen population.

"Even though a clear majority of Americans favor birth control services for the sexually active teenager and endorse sex education in the schools," Furstenberg observes, "some institutional resistance and a great deal of institutional inertia have blocked the development of widespread and intensive sex education and family planning service programs for teenagers. Few populations are as potentially accessible to these services as are school-age youth. Yet school systems have been avoided, bypassed and ignored as sites for pregnancy prevention programs."

While young women 15 to 19 make up 42 percent of the total who need publicly supported family planning services, they account for only 29 percent of the women who actually receive such services, according to a recent study, *Improving Family Planning Services for Teenagers*,[8] by Urban and Rural Systems Associates. This study points out that federally funded family planning clinics are not reaching sexually active young people soon enough, especially those under the age of 14, and when they do, their services are often inappropriate.

The problem faced by minors seeking such services is compounded by anxiety on the part of physicians concerning the old common law rule that the consent of a parent or guardian is required before a doctor may provide any kind of medical treatment for a minor.[9] An equal amount of anxiety is experienced by teens seeking such services. Despite society's seeming openness about discussing sexual matters, there is still great reluctance on the part of adults, including parents, doctors, nurses, and teachers, to accept adolescents as sexually active and consequently a reticence on the part of adolescents to confide in adults about their sexual activity.

On July 1, 1976, in its decision on Planned Parenthood of Central Missouri vs. Danforth, the Supreme Court ruled that parental consent is not necessary for abortion services to minors.

Since the Supreme Court has struck down statutes requiring parental consent for abortion, many legal experts

now believe that such requirements for contraception will also fall because it is generally acknowledged that it is preferable, from the point of view of health as well as other considerations, to prevent rather than terminate unwanted pregnancies.[10] The first step in this process may be seen in the Supreme Court's July 9, 1977 decision invalidating a New York law which forbade all advertising of contraceptives and prohibited all sales or distribution of contraceptives to persons under 16.

Of perhaps greater importance is the Supreme Court's June 20, 1977 ruling that state and local governments are not obligated to pay Medicaid benefits for abortions of an elective or non-therapeutic nature. An estimated 300,000 abortions—most of them elective—are financed annually under Medicaid. Since one out of three abortions are to teenage women and many of these young women are poor and their abortions are financed through Medicaid, the new ruling will undoubtedly have substantial impact on abortions for this age group.

In a related measure, Congress approved a new version of the Hyde amendment which was tacked onto the Fiscal 1978 Labor-HEW Appropriations bill (H.R. 7555). It bans the use of federal funds for abortions, except where the life of the mother would be endangered if the fetus were carried to term.

The Federal Response

This Congressional mood is wholly supported by President Carter who answered critics of the Medicaid decision with the advice that "life is unfair." His tough-minded attitude is also reflected by HEW Secretary Joseph Califano who, during his confirmation hearings, made it clear that he does not favor using federal money to finance abortions. Instead he proposed a $35 million package of options for Fiscal 1978 labeled "Alternatives to Abortion."

Teenage pregnancy appears to be a priority item in all categories of these budget requests. For example, $14 million was added to the Fiscal 1978 budget for community health centers to extend comprehensive services, including family planning, health education, counseling, and outreach, with emphasis on reaching sexually active teenagers. The budget for Family Planning Project Grants was increased by $10 million in order to reach an estimated 278,000 low-income teens on the note that both the courts and state legislatures have begun to affirm the right of young people to be responsible for their own health care in general, and contraceptive services in particular. Other categories increased included $5 million for biomedical research on reproduction and prenatal development; $2 million for sex education research and demonstration projects focusing on reducing the rate of teenage pregnancies; and $2 million for research and demonstration projects aimed at increasing adoption of hard-to-place children as well as improving care of those in foster homes.

Congress approved, and in some cases increased, these items in the Labor-HEW Appropriations bill for Fiscal 1978.

To those not familiar with the crucial needs in this area this extra funding might seem impressive. However, it is nothing less than grudging in view of the massive job that needs to be done if young parents, and sexually active youth are to have adequate health care and necessary social services. In its 1976 report to DHEW's Assistant Secretary for Planning and Evaluation/Health, Urban and Rural Systems Associates made recommendations based on its national study of 40 clinics within each of the major metropolitan areas.[11] Among its conclusions:

- Unless DHEW establishes youth under 18 years old as a national priority and acts to support that priority programmatically it is unlikely that the number of teenagers served by organized family planning programs will be increased substantially.
- In addition, DHEW should consider expanding its concern to include all sexually active youth under age 18. The youngest patient encountered in the course of the study was 12 years old. Some clinics, however, reported that they have served sexually active youth as young as 10 years old. By focusing only on "teenagers," many pre-teenage youth will be neglected or deprived of contraceptive protection.
- The study team feels that the changes needed at the clinic level will not come about unless more money is available to support special teenage services. Third party payments and private contributions—in the form of both fees and donations—are inadequate sources of support for organized family planning programs. In fact, putting the burden of support onto these sources effectively discriminates against serving young teenagers.
- A nationwide public information campaign designed to acquaint the American people with the personal and social consequences of teenage pregnancy and to develop support for the provision of family planning services to teenagers could do much to create a climate where providers would feel more free—and more able—to actively recruit teenage patients. In addition, it would encourage teenagers who might otherwise be reticent to seek services.
- Further technical research is needed to evaluate the effects of present birth control methods on young patients and to explore the development of new contraceptive methods appropriate for young women.
- Further research is needed around the issues of education and counseling, and their relationship to effective birth control use. Providers currently have no body of research to inform them about the best ways to promote effective contraceptive use.

The principal reason services for young parents and sexually active youth are presently so limited is lack of adequate funding sources. According to a recent NACSAP survey of school-age parent programs and services, the principle source of federal funding are Title XX of the Social Security Act; Titles V and X of the Public Health Services Act; and Title XIX of Medicaid.

Despite the varied nature of these funding sources the degree of their support for programs and services is actually less than it was five years ago. Programs are turning increasingly to state funding that is not tied to federal sources and to local sources, with many relying on United Way or United Givers funding. Needless to say, competition with other groups for a portion of these funds is keen. In most localities the needs of young parents and sexually active youth are given low priority. This is so because there is a reluctance

on the part of policy makers at key levels to accept the reality of adolescent sexual behavior.

Presently there are work groups within DHEW addressing possible changes in the Fiscal 1978 budget that might influence the availability of funds for direct health, education, and social services for pregnant adolescents and young parents. The work groups are an outgrowth of a Task Force on Adolescent Pregnancy and Other Related Issues appointed by DHEW Secretary Califano in mid-June of 1977. Specifically, the Task Force was charged with the development of a Fiscal 1979 program plan with attention to funding support to be made available from several different agencies within the Department. Recommendations were made to the Secretary in late August when the Task Force completed its work. However, no final decision has been made by the Secretary about Fiscal 1979 expenditure levels as of this writing.

Legislative Initiatives

Because groups such as NACSAP have been active in the advocacy role at the national level, Congress has recently become interested in the problems of young parents and a series of legislative proposals to improve and increase services to young parents have been introduced.

In 1975, Sen. Edward M. Kennedy (D-Mass.) and Sen. Birch Bayh (D-Ind.) introduced bills to aid school-age parents. During the course of the hearings on the School-Age Mother and Child Health Act of 1975 (S. 2538), sponsored by Sen. Kennedy, Sen. Bayh testified to express his support for the Kennedy bill, which was essentially a formula package to give states money on the basis of the actual number of live births to teens. The bill did not receive enough support to move it out of the Senate Labor and Public Welfare Committee, and in effect, died. A similar bill was introduced in the House but no hearings were held. In this session, Rep. Gladys Spellman (D.-Md.) has introduced a bill (HR 1330) to provide special health services to pregnant adolescents and was joined by a number of other congressmen in offering a companion bill, HR 2357, the Life Support Centers Act of 1977. Other bills relating specifically to pregnant adolescents or selected needs in the fields of health and social welfare have been introduced but to date no hearings have been held on any of these measures.

Another approach that may have a better chance is a national health insurance plan for children and pregnant women. Rep. James H. Scheuer (D-N.Y.) and Sen. Jacob Javits (R-N.Y.) introduced similar measures in the 94th Congress. Many observers consider these proposals a trial run for future national health insurance legislation.

Under such a plan, pregnant women would be entitled to all care required during pregnancy and delivery. Payment would be financed through payroll taxes matched by general revenues. Employes and employers would pay a new one percent tax on wages. The estimated federal contribution would be about $11.7 billion a year. There would also be a ten percent co-payment charge for some services. Low-income persons would not have to make co-payments and would be entitled to special supportive services such as transportation, babysitting, and counseling.

For Future Consideration

In viewing the consequences of adolescent sexuality, one of the real problems up to now has been the one-sided emphasis on the woman's role. Commissioner Marland's 1972 statement reflects a split-level view of sexual responsibility for pregnancy and parenthood. Not until the third paragraph is the parental role of the father acknowledged. The child is also mentioned at this point as is the need for a strengthened family structure. Such statements appear to be mere lip service in light of society's overwhelming failure to admit that teen and pre-teen parenthood involves a father as well as a mother.

The last paragraph of the Marland statement hints that the focus should be on education for parenthood. Such a program was initiated in 1974, sponsored by the Office of Child Development in cooperation with the Office of Education. An experimental curriculum, Education for Parenthood, was tested in selected high schools around the country. It features courses designed to help high school students understand the principles of child development in preparation for future parenthood.

Admirable as such an effort is, it suffers from a glaring omission—instruction on how and why people become parents. It would seem that a course in Education for Parenthood would be an excellent means of introducing a course in sex education. However, in most states such a course is still considered controversial if not illegal. Among the 50 states only seven mandate a course in family life/sex education.[12] Many states have statutes forbidding any instruction on birth control or the human reproductive system.

There is also a need to incorporate sex education into programs for school-age parents. There is a kind of ambivalence about this, a feeling that when young women and men become parents they know everything there is to know about sexuality and parenthood. It is ironic that when they are experiencing the reality of parenthood and their own sexuality they receive so little in the way of supportive information that could enable them to cope with their real life situations.

U.S. Commissioner of Education, Ernest L. Boyer, stated in a recent interview[13] that in his opinion "the most dramatic reforms in American education during the next five to ten years will occur in the high school." He noted that young people are maturing earlier and are frustrated by confinement within the rigid structure of our present school system. He believes a model that would provide different alternatives for different students" is the key to a more open and effective learning situation. "Some models could include part-time in the high school and some time in an apprenticeship," Commissioner Boyer suggested.

Such a solution would certainly help young men and women who are parents to bridge the gap between school and work. Apprenticeship while still in school would give them the necessary experience without which it is almost impossible to enter today's job market. If young parents had the option of going back to school or going to work, then back to school later, with credit for their work experience, they would be better equipped to compete in the world of work.

One sign that the Administration may be thinking along these lines is the work of the Federal Interagency Committee

on Education. Established in 1964, the Committee has been reactivated, with the Assistant Secretary for Education as chairperson. Representatives of over 30 government agencies, including the Departments of Labor, Defense, Agriculture, State, and Commerce, have been meeting to look at issues involved in coordinating federal education programs. Among the major categories identified is the need to consider the relationship between educational training and work and the need to equalize educational opportunity and access.

However, if such new initiatives are to be helpful to young parents, they will need to include adequate provisions for infant day care, family planning and other necessary health and social services.

There is also the question of inadequate enforcement of Title IX's section 86-40, insuring equal educational opportunity for pregnant women. This regulation has not had a significant, let alone modest, impact on the administration and development of school-age parent programs.

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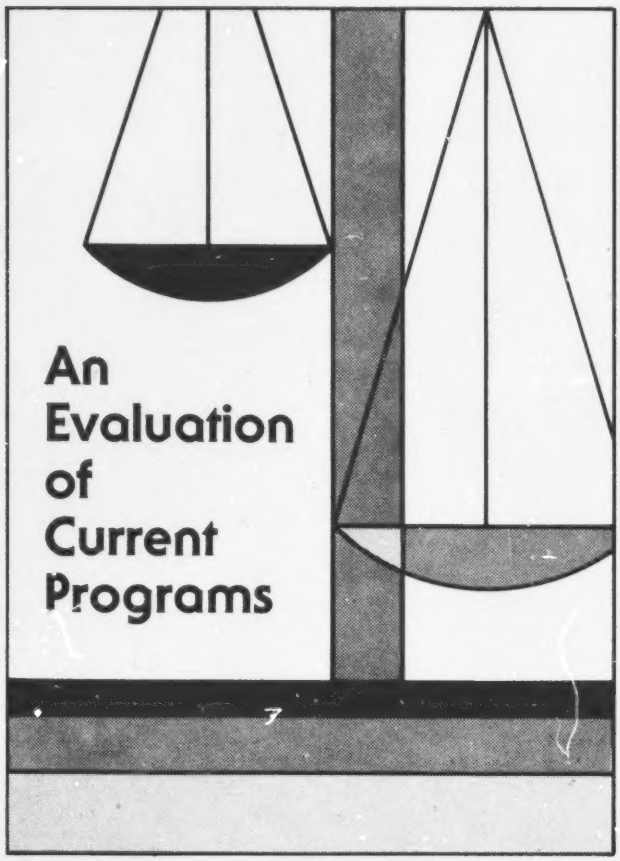


Until recently current and detailed information about services for pregnant adolescents, school-age parents, and sexually-active youth has not been readily available. This is largely a result of a few strikingly important characteristics of the efforts initiated at national, state, and local levels in behalf of this group of young people.

First of all, the history of public interest and concern for the contemporary needs of pregnant teenagers and school-age parents as a special interest group is relatively brief. Only in the late '60's, through the efforts of both the Cyesis Programs Consortium (later known as the Consortium on Early Childbearing and Childrearing until its closing in 1975) and NACSAP, were pregnant adolescents and school-age parents singled out for attention because of the vast and compelling array of human service needs they experience.

Second, because the needs of pregnant adolescents and school-age parents represent such a formidable "shopping list" in terms of the services required for their resolution, the number and variety of public and private agencies involved in serving them is, in turn, extensive. Whereas a few of the public and private agencies described have developed a comprehensive approach to this population, most of them are set up to serve either the health, education, or social service needs of young parents. Even more important is the fact that few human service agencies have set a priority on responding to the needs of school-age parents and pregnant adolescents.

When NACSAP was founded in 1969, it set out to create a multidisciplinary "alliance" among service and policy-making agencies involved with pregnant adolescents and school-age parents. Since then the Alliance has promoted the acquisition and exchange of information and approaches relative to the reduction of risks associated with adolescent pregnancy and primary prevention of adolescent pregnancy.

Early in 1977 NACSAP conducted a national survey of 50 agencies chosen from a stratified random sampling of those providing services to pregnant adolescents, school-age parents, and sexually active youth. Funded by the Joseph P. Kennedy, Jr., Foundation, the purpose of the survey was to obtain information on the extent to which these agencies actually are impacting on the needs of this client population; to identify sources of financial support for services presently offered; and to identify gaps in those services.

For purposes of this study NACSAP classified the agencies according to the variety and extent of services they offer. Class A agencies provide health, education, and social services to adolescents during pregnancy and for a clearly defined period postpartum. Class B agencies provide services in any two of the above categories and Class C agencies offer support in one of these areas only. The eleven agencies offering only referral information were not included in the sample.

A stratified random sample was used with a sampling fraction of 1/5 for Class A agencies and 1/23 for both Class B and C. A higher sampling fraction was needed for Class A because of the relatively small number of agencies in that class.

The response rate for the 3 agency classes was 9/10 (90%) for A; 16/18 (88.8%) for B; and 17/29 (58.6%) for C. The overall response rate was 42/57 (73.6%). Of the 42 agencies that actually participated in the survey, 21.4% were Class A. 38% B, and 40.4% C.

The basic data collection method was an extensive questionnaire, followed up in forty communities by a site visit from NACSAP staff or a consultant. During the site visits respondents were able to discuss any questions or problems resulting from their work on the questionnaire. Anecdotal information was also obtained during the site visits to augment the standardized questionnaire.

Some of the findings of this survey:

Duration of Services

The duration Class A and Class B agencies have been serving pregnant adolescents and school-age parents ranged from 1 to 147 years. The Class A agencies had been serving the population an average of 81 years, whereas B agencies had been serving pregnant adolescents and school-age parents an average of 13 years.

This finding, perhaps surprising to some, reflects the nature of the A and B programs. Most of the A agencies, those that provided comprehensive services, were residential centers such as the Booth or Crittenton Homes and these have

a long history of services. The residential homes were the forerunner to the comprehensive service programs promoted during the late sixties and early seventies. Most of the services provided by B agencies represent community programs developed since 1960.

It is clear that most of the community programs are not truly comprehensive. This reflects problems of financing and coordination of other services in the community, as well as the history of the agencies from which they sprang. In terms of the financial problems, Class A, B, and C agency staff all reported extreme difficulty in finding out about financial support for services both at the state and federal level.

Source of Clients

Most of the agencies reported that self-referral, referral by family, peers, friends, and other agencies were all important sources of their clients. In addition 21 of the 23 Class A and B agencies made some special efforts to seek out young mothers. Of the reporting programs, 85% used some kind of literature to make their program known, 50% used the media, 57% used personal outreach, and 25% used some other methods. Although most agencies did report the use of printed materials describing the service(s) available, in many instances brochures were made available only to persons who actually came to the agency.

Despite this outreach, about half of the agencies had to deny services to some young mothers, although this did not represent a large number of prospective clients. For those reporting, the average number of young mothers denied services per year was 18, with a range from 4 to 39.

The estimated percentage of the target population of young mothers reached by the agencies varied from 1% to 95% among the 11 agencies answering this item; the A agencies reached an average of 24% of the target population, and the B agencies 20%. It is noted that respondents appeared to have great difficulty in determining what the size of the target population was in the area served by their program. The reliability of the estimate of the % actually served should be interpreted in light of this.

Funding

The agency budgets varied from $1,000 to $672,000 per year. Not surprisingly, Class A agencies, which were often residential homes, had significantly larger budgets (from $49,000 to $672,000 per year, with an average of $200,000) than did the Class B agencies (range of $1,000 to $318,000, with an average of $70,500). Since few of the agencies surveyed were primarily focused on the provision of services to school-age parents but included them in their agency program, budget data were occasionally prorated according to the percentage of school-age parents in the total population served.

The percentage of agency funds derived from the federal government varied from 13% to 75% among the programs that received any. Five (63%) of the Class A agencies received some federal funds, and these varied from 13 to 75% of the budget (only one program had more than 30% from Federal sources). Among the federal sources cited by Class A agencies were Titles XIX and XX of the Social Security Act; LEAA—Juvenile Delinquency Prevention Act; and Department of Agriculture food surplus funds.

By contrast, only 3 Class B agencies (20%) reported the use of Federal funds directly; 2 of these received 50% of their funds from this source, and one 75%. Indirectly Class B agencies did use more federal monies with the most frequently cited indirect source being Title XIX of the Social Security Act. Generally, agencies were familiar only with federal support in the discipline area in which they provided the bulk of services. For example, social service agencies were often familiar with federal social service funding sources but rarely had knowledge of what was available through federal education programs.

More of the agencies, particularly those in Class B, received money from their states (much of which may have been from federal grants to the states). For example, 87% of the Class A agencies received some state funds, from 5% to 80%, and 9 (60%) of the Class B agencies received state monies (from 10% to 100% of all funds for these 9 programs).

Cities and counties, particularly for Class B agencies, are a particularly important source of funds. Of the Class B agencies reporting, 40% reported cities and counties as sources with a range of 5% to 80%. Only 2 (25%) of the A agencies received city or county funds; 1 had 1% and the other 40%.

Private sources were important for the Class A agencies, as might have been expected from their historical origins. Seventy-five percent of the Class A agencies received money from private sources, with from 9 to 65% from this type of source. By way of contrast, there was little support for B agencies (2 programs, with 10% and 41% from these sources).

United Way contributed to many Class A and Class B agencies. For the 63% of Class A agencies receiving United Way monies, this source provided from 15% to 45% of their budgets, with an average of 30% from this source. Only 27% of B agencies received United Way funds, and their percentage varied from 7% to 100%, with an average of 56% for those reporting this source. Thus, even though relatively few Class B agencies received United Way funds, it was an important source for those who did. Furthermore, in discussions with staff and consultants during the site visits, Class A and B agency representatives reported efforts then underway by their respective agencies to secure new and/or additional support from local United Way sources. In some instances this was viewed as a more dependable, potentially long term funding source than federal or state programs.

In summary, there is no single or typical pattern of funding for school-age parent services. The different histories, services, and locations have generated a mosaic of funding patterns using federal, state, city or county government, private, United Way, and other sources. In many agencies, the multiple funding reflects the multidisciplinary nature of the agency's effort to impact on the needs of pregnant adolescents and young parents. In others it is a desperate attempt to find even makeshift funding to keep a program together. By contrast, an agency with only one major funding source might only reflect a lack of awareness for what other support might be available. Whatever the circumstance, for those agencies with multiple funding sources, that very characteristic imposes difficulties in planning, administering, and

evaluating the services provided to pregnant adolescents and school-age parents.

The number of programs receiving direct federal funding and the proportion of total funding from that source, was less than might have been expected in view of informal reports submitted to NACSAP by members in recent years. On the one hand, that suggests the positive conclusion that existing agency services are becoming more indigenous within their local communities and states. On the other hand, it suggests that judicious use of federal funds might strengthen many programs that are in serious difficulty. The latter is perhaps the more reasonable conclusion in view of the tenuous funding state of many of the agencies included in this survey.

Services Provided

The variety of Class A and B agencies involved in the survey in part predetermined the range of services they provided to pregnant adolescents and their families during the prenatal period and/or following delivery. For those that were predominantly health-oriented agencies, the health services provided were understandably more comprehensive. The same was true for social service and education agencies.

In terms of prenatal health care the most frequently offered service in Class A agencies was nutrition education. Six of the Class A agencies (75%) provided this as a part of their program. It was also the most frequently provided service among Class B agencies (10 to 15 or 67%). Class A agencies involved a range of 18-262 clients in nutrition education as compared with a range of 26-600 clients in Class B nutrition education services.

A somewhat surprising finding was that none of the Class A agencies were involved in pregnancy testing. Only 3 (20%) Class B agencies offered this service. (In part this is understandable for Class A residential agencies historically set up to respond to the needs of young women who are already pregnant and have been referred from other agencies.) For Class B agencies it suggests that when the focus of the agency is other than health care, a service that is clearly in the health arena is not considered essential.

Only five Class A agencies (63%) make contraceptive information available to their clients with a range of 18-262 clients involved. Eight (53%) of the Class B agencies address this need serving between 31 and 450 clients. It is the policy of one of the private agencies *not* to provide contraceptive information. Despite the availability of the USDA administered WIC program, few Class A and B agencies were taking part in that or alternative food supplement programs. Four Class A agencies (50%), with a range of 22-140 clients served, and 1 Class B agency (7%), serving 304 clients, offered food supplements.

Only 1 (13%) Class A agency provided pediatric care to 90 young women and four (27%) Class B agencies with a range of 33-225 clients.

Generally the Class A and B agencies in this survey appear to be fairly responsive to the education needs of pregnant adolescents. All Class A agencies provide for the continuation of a regular school program either through on-site classes (in the case of residential programs) or through cooperative agreements with local education agencies. (None of the Class A agencies were education agencies). The number of clients in the education program ranged from 11-180. Eleven (73%) Class B agencies offered pregnant adolescents the opportunity to participate in a regular school program serving a range of 4 to 600 clients. The agency serving 600 clients was a special school program in an urban area reporting for two academic years.

Two of eight (25%) Class A agencies included physical education as a part of the educational program involving 16 and 30 clients respectively. Similarly only two Class B agencies (13%) serving 12 and 34 clients each offered physical education.

Remedial math and English were offered by 5 Class A (63%) agencies and involved a range of 3 to 160 students. Six Class B agencies (40%) with a range of 3-540 clients offered remedial math services. Only 5 Class B agencies (33%) provided remedial English with a range of 5-166 students.

Surprisingly few pregnant adolescents—a range of 10-60—participated in parenting education classes in 6 Class A agencies (75%). This was a required course in only a few of those agencies. Six Class B agencies (40%) with a range of 22-600 students offered parenting education. In view of the generally widespread interest in parenting education which has surfaced in the past two and one-half years, there appeared to be fewer opportunities for pregnant adolescents to participate in this type of course than might be expected of a group that is poised on the edge of parenthood. Most agency representatives did express considerable interest in making this course a part of their program and viewed it as an important element in addressing prevention of subsequent pregnancies.

The most frequently offered social service available to pregnant adolescents and school-age parents both in Class A and B agencies was individual counseling. All eight of the Class A agencies offered this service with a range of 3-717 clients. While all Class A agencies also offered group counseling, this service reached a smaller range of clients—30-262.

Only four (50%) of the Class A agencies offered a complete range of adoption services serving a range of 6 to 178 clients. Seven of the Class B agencies (47%) met this service need with a range of 10-129 clients. Many agency representatives reported that there was little interest on the part of the pregnant adolescent for this service. A few indicated that since the adolescent mother comes into the agency fairly late in the pregnancy, personal decisions have often been made with regard to the placement of the infant and counseling intervention on this matter as well as others is often "after the fact." In contrast to reports from service providers regarding the relative lack of interest on the part of adolescents in adoption as an alternative to early parenthood, the youth caucus at NACSAP's 1976 National Conference on School-Age Parenthood expressed the contrary, urging providers to present this as well as other options in a 'bias-free' climate. This apparent difference of interpretation of the preferences of adolescents between adults and young people warrants serious consideration in the development of additional service programs. It suggests the need for careful attention to staff training needs both at pre- and in-service levels.

This study also reported a series of urgent needs facing pregnant adolescents and school-age parents which were not being adequately addressed by Class A, B, and C agencies. Among the needs cited was infant day care; direct financial aid to young mothers and their infants; and housing. The latter was usually characterized as short-term group home or independent living quarters to which a pregnant adolescent could turn during pregnancy or immediately after delivery until personal crises were eased. With regard to what is presently being done in these areas, 3 Class A agencies (37%) made infant day care service available providing assistance to a range of 2-175 adolescent parents. Only 3 Class B agencies (20%) with a range of 20-33 young mothers made this available. Five Class A agencies (63%) with a range of 11-225 clients and 5 Class B agencies (33%) with a range of 18-195 clients provided direct financial assistance. In the case of some of tho Class A agencies, a small fund generated from private sources is maintained for emergency assistance to young mothers. Because of the vastly different nature of the agencies in Class A and B, the latter have not as yet established this type of on-site assistance.

Housing arrangements for pregnant adolescents were virtually predetermined in some Class A agencies since most are residential programs. Six of the Class A agencies (75%) provide housing arrangements at least for the duration of the pregnancy and often for a short time after delivery. Only 5 Class B agencies (33%) serving a range of 10-44 adolescent mothers were involved in arranging for or providing housing assistance. While admittedly a controversial service area in terms of possible implications for the family unit of which the adolescent parent is a part, this service need does require considered attention. Though on the one hand it could be argued that the provision of short term alternative living arrangements to pregnant adolescents and/or young mothers and their infants would contribute to the breakdown of the original family unit, on the other hand, short term separation of that family might well ultimately strengthen it and establish a better climate for all of the parties when it appears likely they can once again live together with reasonable harmony.

The questionnaire used in this survey identified a cluster of vocational services needed by pregnant adolescents and school-age parents as contrasted with vocational training available within the standard educational program. Seven Class A agencies (87%) provided employment counseling to a range of 10-225 clients. Of the 15 Class B agencies in the study sample, 5 (33%) offered employment counseling to a range of 12-166 clients. Many of the agencies reported extreme difficulty in placing adolescents in jobs and actively sought advice during site visit discussions as to ways in which NACSAP or other resource agencies could be helpful to them in locating job opportunities. Reflecting this difficulty, only 3 (37%) Class A agencies offered job placement assistance to a range of 2-225 young women and 2 Class B agencies (13%) serving 7 women. One Class B agency (7%) and 4 Class A agencies (50%) provided direct job training chiefly in the areas of clerical and child care positions.

One of the most disturbing findings of this study was the relative lack of follow-through services available to young parents after delivery. For example, Class A agencies offered most services only for a period of 6-12 weeks after delivery. An encouraging sign was that seven Class A agencies (87%) offered individual counseling for a period in excess of 52 weeks. This was the most frequently provided follow-through service by Class A agencies. In discussions with agency representatives, however, it was pointed out that there wasn't an activist approach to this service since most agencies were struggling to meet the needs of the adolescents who had not as yet delivered. Eleven Class B (73%) agencies offered individual counseling after the birth of the baby for a time period of 13-24 weeks, a much shorter period than reported for Class A agencies. Of all the services reported as most needed and not now available, agency representatives cited follow-through support as the most critical. This was also identified as an important factor in helping young parents to avoid an unplanned, repeat pregnancy. Four Class A agencies (50%) reported the availability of follow-through family planning services for a time period of 13-24 weeks following delivery. Six Class B agencies (40%) offered family planning services after delivery for a range of 7-12 weeks.

While many Class A and B agencies indicated that they employed a referral process for family planning services, it was difficult to clearly establish the process for its implementation once a young mother was no longer a primary client of their agency. Certainly the opportunities for young mothers to "fall through the cracks" in terms of family planning services seemed more apparent than did the opportunities to be involved in sustained family planning intervention programs.

Young Fathers

Not surprising was the evidence documenting the extent to which young men are not included in school-age parent service programs. Only two Class A agencies (25%) made family planning information available to fathers or partners and no Class B agencies provided this service. Five Class A agencies (63%) and 5 Class B agencies (33%) did provide individual counseling to fathers. In Class A agencies this service was available for 52 weeks and for Class B agencies for 13-24 weeks. All agencies reported interest in serving this population but cited the lack of financial resources and staff as primary deterrents to incorporating young men into school-age parent programs.

From an economic standpoint, pregnant adolescents and school-age parents represent a population at considerable risk of long term welfare dependency unless comprehensive intervention measures are established. Class A agencies reported a range of 3-100 clients on public assistance at the time of intake and Class B agencies reported a range of 3-540 clients in this category. In the case of the agency reporting 540 clients, it represented 100% of the caseload for a one year period. The most frequently used single source of financial aid for prenatal care among clients in Class A and B programs was Title XIX. An average of 43% of clients in the Class A agencies used Title XIX; an average of 47% of the clients in Class B agencies used Title XIX.

A recent colloquium sponsored by the Child Welfare Resource Information Exchange through funds provided by the National Center for Child Advocacy, DHEW, identified three categories of persons who need specialized training in the provision of services for pregnant adolescents, young parents, and sexually active youth. They are:

- Service providers who work directly with the client population;
- Decision makers and/or program administrators;
- Interested community members.

The category of service providers can be further divided into two subgroups:

- Professionals working through agencies which provide some type of specialized assistance to young people who are pregnant, who are parents, or who are sexually active;
- Staff members of school-age parent programs.

It is through the latter group that the small movement to provide comprehensive services for pregnant adolescents evolved. However, it is becoming increasingly evident that it is the more general group of service providers who are in greatest need of specialized training. This was brought out by NACSAP's recent survey for the Kennedy Foundation (pp. 19-22) which reveals that school-age parent services are rarely a priority for community agencies but rather are included in programs designed to meet the needs of other interest groups.

There are certain basic areas in which all three categories of persons working with young parents and sexually active youth should be knowledgeable. They include:

- Information about the extent of the phenomenon of adolescent pregnancy;
- Information about the consequences of adolescent pregnancy;
- Knowledge of current local, state, and federal policies influencing services delivery;
- Awareness of available resources and the definition of the issue within local agencies, institutions, and the community at large.

Over several years of experience in relating to program administrators and service providers, NACSAP has defined the following areas in which they have need for more specialized training:

- *Self awareness*—A communication gap between the provider/administrator and the client is often the result of the provider/administrator's perceived notion of the client as contrasted with the reality of the client.
- *Networking*—A caseworker, for example, needs to know what services are available within the agency and where to refer the client outside the agency when such services are not available.
- *Case Management Techniques*—There is a need for practical experience in serving this particular client population, and knowledge of how to bring together necessary specialized services.
- *Current policy information*—A practitioner should be aware of any special guidelines or regulations issued by federal agencies, state departments, or related local agencies that affect services to this client population.
- *Information sharing*—Service providers and program administrators need to relate to others who are working in this field through conferences, articles, newsletters, etc.
- *Funding sources*—There is a need for specific information on sources of support for services available from government agencies, private foundations, and individual or community contributors which would help to establish a stronger base for program services.
- *Evaluation*—There is a need for guidance on how to judge and review services provided.
- *Research*—There is a need to learn how to use existing research for purposes of strengthening the quality of services.
- *Model Programs*—There is a need for service providers and program administrators to know the ingredients for the basic components of a comprehensive program and how to develop such a model. There is also a need to develop contemporary guidelines for services to pregnant adolescents, young parents, and sexually active youth.

As a result of several technical assistance contracts with the U.S. Office of Education, DHEW, NACSAP has developed a unique area of expertise which embraces all of the training needs listed above.

NACSAP has functioned in two distinct modes in providing technical assistance to the school-age parent field: first as

an initiator-to promote awareness, understanding, and action directed toward the resolution of problems associated with adolescent pregnancy, early parenthood, and sexually active youth. Second, as a responder to those seeking information, ideas, and/or related assistance which will help them deal with these issues at the local level.

As an initiator, NACSAP's work under its first USOE contract in 1973 was frequently focused on introducing not only the issue but the organization itself to contacts in the field. While the contract support enabled this to be done in selected states, the general membership resources of the organization, which most often were translated into voluntary time, enhanced the activity in those states and carried it over to non-contract areas. Increasingly as time passed, the broader recognition of the school-age parent phenomenon and expanded understanding of NACSAP helped link it to other special interest membership associations and organizations at the national level. These relationships have been useful in turn in assisting statewide school-age parent organizations expand their circle of contacts.

As a responder, there were some established contacts in 1973 which were already dependent upon assistance from NACSAP. In part this was the case because NACSAP had sponsored a number of school-age parenthood conferences through previous funding from the Maternal and Child Health Service (DHEW) but also as a result of the existing membership base and outreach by the NACSAP Board of Directors and staff. Most of the requests from individuals at that time related to the need for information about special school-age parent programs such as how to develop and fund them and/or evaluate their effectiveness and/or basic information about adolescent pregnancy. There was also considerable interest in what others were doing. At another level requests emanated from statewide organizations such as the Wisconsin Alliance Concerned with School-Age Parents and the Illinois Association for Comprehensive Services to School-Age Parents which sought assistance in conference planning and follow-through.

One of the recognizable trends now is that the demands for technical assistance are considerably greater, more sophisticated, and originate from many more levels of organizations and institutions both within and beyond the original target states. It is impossible to determine the extent to which NACSAP's presence has contributed to and/or influenced this general trend on a national basis but based on feedback from key contacts in a selected sample of contract states, without NACSAP's promotion of the concept of technical assistance, field people would not be as far along in their ability to ask for assistance. In other words, a part of NACSAP's technical assistance was in helping field contacts learn how and what to ask for in developing programs.

Another noticeable trend is that technical assistance is now being requested by individuals and/or organizations which do not have as their primary purpose responsibilities for the provision of direct services to pregnant adolescents and/or young parents. For example, informational requests and/or requests for speakers/resource persons are regularly received from college and university departments which are establishing a parenthood education course or perhaps an adolescent medicine program; or generating graduate theses on adolescent pregnancy. Another example of the type of request coming from those outside the mainstream of direct services is the demand for information and assistance from other associations and the media. This also suggests that the advocacy movement is now less dependent upon only health, education, and social services and increasingly looking toward a more diversified constituency for support including funding.

A practical aid which has gained attention in this area and is frequently requested has been assistance in developing promotional, public relations oriented materials to help "tell the story" in a local community. Chief among the aids which NACSAP suggested was a fact sheet citing basic details about the extent of the problem and noting the level of remedial and preventive services available in the community.

Due to the popularity of parenthood education, another trend evidenced in the technical assistance program has been the emergence of parenthood education as a means of impacting on school-age parenthood from a preventive standpoint. And, closely related to this is the initiation and response of NACSAP which now prominently addresses the prevention of adolescent pregnancy through the provision of additional resource materials in this area and the identification of resource persons/organizations.

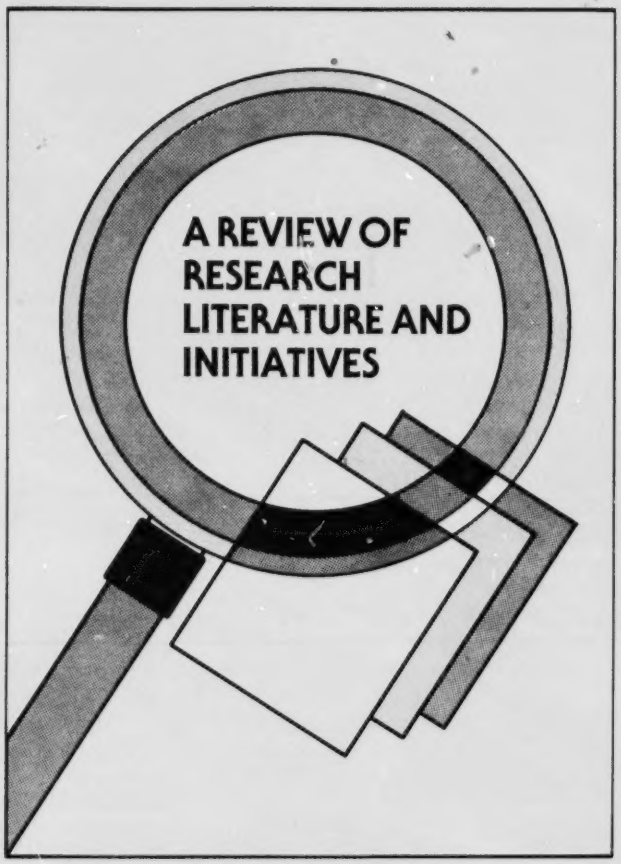
Conferences yet remain one of the most if not *the* most efficient means of informing larger groups about this issue as well as providing a forum for the exchange of techniques and ideas about programming. However, in terms of trends, there are fewer requests for assistance in planning conferences—especially from states in which there are statewide organizations than was the case in 1973. Rather, the conference related requests are shifting somewhat to call upon NACSAP to provide assistance in the development and implementation of in-service training institutes. This represents an entirely new area. The institutes have been multidisciplinary, though a local association in Maryland has begun to plan for a training seminar for a single professional group.

During the 1975-76 period of the USOE contract, interest in research and its application to program planning and operation became a more prominent focus of technical assistance efforts. This was a mixed blessing in that the research which had been funded was in some instances, not universally applicable to an adolescent parent population. Yet it was being reported as so in the literature. The result was that in responding to inquiries and calls for documentation the existing literature was not entirely appropriate. Because there is so little information available, NACSAP has had to rely on what exists. In projecting toward the future, given the increased attention and support on the part of Federal agencies such as the National Institute for Child Health and Human Development and the National Institute of Mental Health for adolescent childbearing research, perhaps this situation will be resolved as more documentation is presented. Increased participation of the private and voluntary sectors in underwriting research will also serve to meet the need for more qualitative documentation.

Not yet a trend but clearly a development evidenced during the life of the USOE contract was the interest on the part of service providers for suggestions as to how to include consumers in the planning and policy-making affecting their program. This was of low prominence until the final contract period which started less than a month after the 1975 National Conference. This relationship is drawn since NACSAP spent considerable effort in establishing a youth caucus to

participate in the meeting and has promoted the concept of youth participation. Behind this is the possible assumption that peer influence might be more effective in stemming the tide of adolescent pregnancy than intergenerational influence.

In summary, technical assistance demands were predominantly informational and school-age parent program related in 1973. In 1976 the program reflected the diversification of interest and concern of prior development. It also points out that technical assistance is a workable strategy for impacting on a sensitive social issue—adolescent sexuality. The key to its success is in keeping the technical assistance program fluid enough so it can respond to the ever increasing demands of a larger public expressing interest in the issue. Because there is relatively no standardization of need but rather individualization of need, the framework for technical assistance application requires constant updating and change. Because NACSAP is a small non-institutionalized organization which depends on input from its constituents, it is well-suited to the conduct of such a program. The implications of these trends for the Alliance as an organization are not yet crystallized but do pose potential for its development as a more broadly focused youth serving agency.



Adolescence is the time between the beginning of puberty and the completion of bone growth. This biological definition is one of the few points of agreement about that period in the life span marking the transition from childhood to adulthood. The disciplines of biology, psychology, and sociology have a variety of theories about adolescence, some of them complementary, some conflicting, but there is little dialogue among them.[1] Erikson's theories on the identity crisis dominate psychology. This view sees adolescence as a period of moratorium, a time to integrate outer and inner growth. Some sociologists contend that adolescence is an artificial concept invented in America—a time tacked onto childhood to prepare youth for entry into the labor market.[2] Others believe the experience of adolescence changes in the context of historical and socio-economic periods; for example, adolescence during the Great Depression of the 1930's was a different experience than adolescence in the affluent 1960's.[3] Others see adolescence as an important stage in and of itself rather than a transitional period between childhood and adulthood.[4]

John P. Hill, in *Some Perspectives on Adolescence in American Society*, contends that there is as yet no theory of human development equal to the task of describing the phenomenon of adolescence.[5] The ecology of adolescence—the setting in which the adolescent lives his life—has been largely ignored, he believes. He calls for a new theory that embraces the adolescent in his or her total life situation. This theory would encompass such variables as biological and cognitive changes; roles such as son, daughter, peer, pupil, worker; psychological development, including detachment, autonomy, intimacy, sexuality, and identity; and demographic factors such as gender, social class, ethnic background, and race.

In *Growing Up Forgotten*, the thought-provoking survey of research on early adolescence, Joan Lipsitz agrees that there is little in the way of theoretical framework to undergird research.[6] She concurs with Hill that rather than trying to fit adolescents into specific categories, we should be asking questions that "get at the ecology of the youngsters' day-to-day life." The entire mode of thinking about and serving youth should be reconceptualized, she advises. Yet she sees "serious deficiencies in our abilities to conceptualize alternative modes of thought." Only a handful of researchers are beginning to pose such questions.

If the way of looking at adolescence in general has presented problems in research, the adolescent who is a parent has been all but overlooked. Actual research literature on the phenomenon of early parenthood was almost non-existent in the 1950's and early 1960's when the social climate was quite different. A young woman who was "caught" in a pregnancy was expected to pay the consequences—social ostracism for herself and her child. This attitude reflects the double standard which still prevails in viewing male/female sexual behavior. The man is looked upon indulgently and even frequently congratulated for proving his virility by the pregnancy. The woman, on the other hand, is viewed with a mixture of pity and disapproval. In literature she is the prototypical romantic heroine who has been "more sinned against than sinning." She is Maria in *Faust*, the innocent woman who trusted and is betrayed by her lover; or Hester Prynne who wears the *Scarlet Letter* while her lover, the Rev. Dimmesdale, is idealized by his parishioners. In Victorian novels it is the woman who always "pays" for daring to transgress social norms by an "out-of-wedlock" pregnancy. She is viewed as fortunate if the man agrees to make a financial contribution toward the support of their child.

Research Literature Reflects Social Attitudes

The influence of such deeply ingrained social attitudes is difficult to assess. Indeed, it has even penetrated the research literature. In the 1950's and early 1960's the adolescent parent was included in the catchall category of "unwed mother" with all the social implications of that "problem." The language in even the most sophisticated treatments of the issue was reminiscent of a Dickens novel. The mother was considered an aberrant personality who was "acting out" her various grudges against society—she was angry at her own mother and using the pregnancy to get back at her; she was a potential delinquent with deep psychological problems; she was not able to cope with the responsibility of growing up and was using her pregnancy to manipulate her environment. The father was always referred to as "the putative father," implying that the mother was promiscuous,

that he could have been a number of men among the one she named as the "supposed" or "alleged" father. He was a shadowy figure who was expected to fade into the background. If she decided to go through with her pregnancy and if she was white, the mother was expected to take "shelter" in a maternity home and give up her child for adoption. If she was black, she was expected to keep her child, drop out of school, live at home with her family and become a welfare statistic.

A vivid picture of how socially punitive attitudes affected services to unmarried pregnant women is given in the first computerized study[7] sponsored by the U.S. Children's Bureau. The survey covered over 20,000 single parents served by affiliates of the Florence Crittenton Association of America, the National Conference of Catholic Charities, and the Salvation Army in 39 states and the District of Columbia. Although the study was completed in 1966, it is more reflective of attitudes in the 1950's when banishment was most often the rule for unmarried pregnant women.

The median age of the women served by these agencies was 19.1 years, with only two percent under 15. The median period in which medical supervision began was the fifth month. Seventy-three percent of the women began medical care in their sixth month; 8 percent in the eighth month, and 4 percent in the ninth month. The majority—87.8 percent of the women were white; 12 percent were non-white. Seventy percent chose adoption for their infant. Social casework was most frequently reported as a service that was needed but unavailable.

A New Approach

In the decade of the 1960's, with its ferment for social change, human service providers and researchers were beginning to take a new look at the consequences of adolescent sexual behavior and adolescent pregnancy and parenthood. Part of the initial concept of research utilization (described earlier), which grew out of a new approach to serving the needs of pregnant adolescents, was the need for a link between the research community and program practitioners. The Consortium on Early Childbearing and Childrearing was established to serve as an information sharing unit. Among its first priorities was a literature search in the field of adolescent pregnancy in order to establish an information base for future technical assistance and program evaluation. Under a grant from the Maternal and Child Health Service of the Health Services and Mental Health Administration, the Consortium contracted with researchers in the Graduate School of Public Health at the University of Pittsburgh. The result was *Pregnant Adolescents, a Review of Literature with Abstracts, 1960-1970*[8] by Michael Baizerman, Cynthia Sheehan, David L. Ellison, and Edward R. Schlesinger. This work, published in 1971, is the most comprehensive survey of the field up until that time. The researchers point out that the literature is heavily weighted with articles that demonstrate the size and kind of problem rather than evaluative research, and note that a critical and analytical reading shows most of the studies to be methodologically weak, so much so that care must be taken not to draw unsubstantiated conclusions.

They observe that views on the causes of teenage pregnancy seem to be moving in the direction of sociological explanations rather than psychological or moral, and cite Bernstein[9] who reviews and challenges the single causation theory which held that becoming an "unwed mother" was a purposeful act symptomatic of emotional problems. Bernstein points out that this view limited the range of treatment options open to pregnant teenagers, may apply only to a few single parents, and even those few could benefit if other dimensions of their situation were considered. She argues that evidence of the existence of emotional problems in a pregnant woman who is unmarried may be a consequence, rather than a cause of her situation.

They also cite Shlakman[10] who discusses the traditional distinction made in defining the causes of single parenthood for black women and white women. She points out that it has been considered inevitable and acceptable for blacks but symptomatic of emotional disturbance for whites. The implication of this attitude for service has been that pregnant black teenagers have received little or no care, and whites have usually been confined in maternity homes with psychiatric counseling.

Baizerman et al note that Furstenberg[11] attempts to disprove the myth of normative acceptance of illegitimacy by blacks with data showing that most of a study population of unmarried, pregnant black teenagers were unhappy about their pregnancies and would have liked to have used contraceptives. They noted that Wessel[12] and Walters[13] attribute the increasing rate of teenage pregnancy to such factors as the ambiguity of societal sex norms, and Oberst[14] points to the special adjustment problems occurring in adolescence which sometimes result in sexual experimentation. Several articles stress the lack of adequate sex information on the part of pregnant teenagers and particularly the lack of information about birth control.

One-Dimensional View of Risks

In discussing the health research related to pregnant adolescents the researchers express concern about the "disease ideology" resulting when adolescent pregnancy is conceptualized and studied as a medical problem. Such a one-dimensional view usually excludes several factors thought to be critical, including race, social class, familial and peer relationships, as well as the relationship among these factors. Often such data are available but not collected or not reported, the researchers note.

They concur with the findings of Grant and Heald[15] who reviewed studies of the biologic outcomes of adolescent pregnancy and concluded that assertions that adolescents are a high-risk group for unfavorable biological pregnancy outcomes are loosely based on disparate data from multiple sources. Race, socioeconomic status, parity, and prepregnant obesity can be more significant factors, either alone or in combination, than age itself, according to Grant and Heald.

The researchers also cite National Academy of Sciences findings on the relationship of nutrition to adolescent pregnancy showing that the lifelong nutritional status of the adolescent is a critical determinant of her reproductive performance.[16] This report was instrumental in promoting later efforts of such voluntary organizations as the National Foundation-March of Dimes. Its campaign promoting the relationship of good nutrition and pregnancy is based on these findings.

In reviewing the literature on the psychological, psychiatric, and social work aspects of adolescent pregnancy the researchers note that few of the studies were of adequate experimental design or had adequate samples.

They suggest that future research could benefit by: consensus of concept which could make findings more comparable and lead to cumulative theory building; improvement of research methodology in medical and health outcomes; simultaneous data gathering on personality, mental status, and pregnancy behavior; and sharing evaluation findings with programs.

Baizerman et al also called for longitudinal research beginning before young women become sexually active and lasting until they become pregnant or until a specified time (e.g. ten years later). They suggest that such research should address at least two kinds of questions:

- What are the similarities and differences between adolescents who become pregnant and those who do not?
- What variables, which can be measured prior to pregnancy, affect the pregnancy outcome?

New Questions Raised

A later review of the literature prior to 1976, *Adolescent Sexuality and Teenage Pregnancy: A Selected, Annotated Bibliography With Summary Forewards*[17] by Karen Robb Stewart of the Carolina Population Center, University of North Carolina, further expands the critical approach of Baizerman et al. By including abstracts on adolescent sexuality Stewart broadens the base of inquiry and raises new questions about both the quality and methodology of existing research.

For example, can the sexual behavior of adolescents be charted on the basis of a few national studies with some built in flaws? Stewart points out that "extreme caution must be exercised" in generalizing from such findings. She notes that Kantner and Zelnik's study for the Commission on Population and the American Future[18] (1972) had a "sound research design," a large sample of randomly selected females 15-19; however, its weakness is the absence of males in the sample. She also points out that Sorenson's[19] 1973 study based on a small (411) sample might have been "skewed" away from identifying more conservative attitudes and behavior by those teenagers who refused to participate or were not allowed to do so by their parents.

In reviewing the literature on services for the sexually active adolescent Stewart observes that it is dominated by reports coming out of Sadja Goldsmith's program in San Francisco's Planned Parenthood clinic[20] and L. Gordis' comprehensive pregnancy prevention program in the Sinai Hospital, Baltimore,[21] and points up the disagreements between these two sources. Goldsmith stresses the need for an informal, accepting atmosphere in the clinic. She maintains that the multidisciplinary approach can turn teens off if too many professionals and too much time are involved in providing services and asserts that this may be responsible for the 50 percent dropout rate in the Sinai clinic. Gordis describes the Baltimore program, which inlcuded a pediatrician, gynecologist, public health nurse, social worker, and clinical psychologist and required parental consent for contraceptives. Gordis cites the need for a controlled study to determine if the risk of pregnancy has been reduced by the program.

In surveying the literature on teens and contraception, Stewart notes that most studies concentrate on selected populations and cannot be generalized to the population at large since those studied have some characteristics or behavior which make them non-typical.

The uneven quality of the health risks involved in adolescent pregnancy raises still more questions, according to Stewart. The results of studies which attempt to document these risks are confusing and contradictory. "It has been extremely difficult for researchers to isolate the risks that are due principally to age," she points out. What does emerge from these studies, is that not all pregnant adolescents are subject to the same risks. "Age, race, socioeconomic status, marital status, parity and adequacy of prenatal care act synergistically," and the patterns of these synergisms "are complex and as yet not completely understood," according to Stewart.

A missing factor in this research is the almost total exclusion of the presumably lowest risk adolescent—the white middle-class 16-year-old who is attended by a private physician and delivers in a private or community hospital. "This may well have resulted in an exaggeration of the risks of low age in pregnancy," Stewart points out.

Another important concern in assessing health risks, she notes, is the literature indicating that the medical risks are "established, proven fact." She observes that the authors of the original studies on which many of the claims in later articles are based never made elaborate claims about their definitiveness and advises reading with a critical eye claims made in secondary sources that are unsubstantiated in the primary sources.

Looking at the research on infant mortality Stewart notes that while young women under 16 are indeed in the high risk category in this regard, infant death, even, in the high-risk population, is a rare event. She points out that prenatal care and medical and social risk factors in the mother are important variables. "It is proven from the research that age together with race and its associations of lower economic status, poor health history, and less access to prenatal care produces a higher risk of complications in pregnancy for the young mother and her child.

One persistent problem with the research base is its narrow focus. By the late 1960's many researchers were becoming interested in the phenomenon of teenage pregnancy. For example, The Alan Guttmacher Institute, the research and development division of the Planned Parenthood Federation of America, Inc., was beginning to publish studies on teenage fertility. Such studies were extremely important in establishing public awareness of the rising adolescent birth rate. However, they rarely dealt with the consequences of early parenthood. As Stewart points out, the documentation of the psychological, educational, economic, and marital risks of adolescent pregnancy "is not very complete." Moreover, she notes, the risk element changes as society changes.

NACSAP Initiates Research Role

Mindful of these and other serious shortcomings in existing research, in 1975 NACSAP assumed a leadership role in this area by establishing a research committee which would

not only develop new knowledge in the field of adolescent pregnancy and adolescent sexuality but would encourage communication between the research community and practitioners at the program level. The need for this type of communication was documented in an informal telephone survey conducted by the Office of Special Programs, U.S. Office of Education. The survey revealed that in day-to-day work with young parents, practitioners were not making use of existing research while at the same time they were asking questions that researchers were not investigating. Another factor pointing to such a need was the overwhelmingly positive response to a series of research sessions held at NACSAP's 1975 national conference.

As a result, NACSAP, in cooperation with the Office of Special Programs, USOE, and with some support from the Joseph P. Kennedy, Jr., Foundation, formed a research committee with representatives from a variety of disciplines, including sociology, public health, medicine, psychology, education, and behavioral science. After several initial meetings for the purpose of considering the direction of current research, suggesting topics for investigation, and developing guidelines for the application of research to program efforts, the following needs emerged:

- a program of research directed toward primary prevention;
- a definition of criteria for program development and operation;
- a research strategy for program evaluation on a national basis;
- increased communication between researchers and practitioners.

In keeping with the above guidelines, NACSAP's 1976 research symposia focused on priority issues such as program evaluation, self-concept and employment potential of young parents, sexual development in adolescence, how prevention can be affected by adolescent thinking processes, and the long-range effects of comprehensive service programs.

Some of the following points were brought out in research papers at the 1976 NACSAP conference:

Frank F. Furstenberg, Jr., associate professor of sociology, University of Pennsylvania, reported on his study[22] of adolescent mothers in Baltimore which highlighted the socioeconomic consequences of early pregnancy. He noted marked differences in the career patterns of adolescent mothers and their classmates who avoided pregnancy. Those who became mothers were more likely to drop out of school, suffer unemployment, and have repeat pregnancies. Furstenberg cautioned against drawing sweeping conclusions from this study and pointed out the need for further research, especially on how the consequences of early parenthood are affected by the provision of services. He noted that virtually no research exists on the receptivity of school and community officials to the need for expanded family planning programs and the kinds of programs which might be acceptable. Also in need of further research is the effect of employment on family formation and stability.

Lorraine V. Klerman, associate professor of public health, Florence Heller Graduate School for Advance Studies in Social Welfare, Brandeis University, reported on a study[23] of the factors affecting a group of adolescents' decision to deliver or have an abortion. Under a grant from the Joseph P. Kennedy, Jr., Foundation, Klerman and colleagues administered a 21-page questionnaire to an individually matched group of 153 single, never-married women 16 to 18 years old. Among the significant conclusions: few of the young women had what could be termed "high quality" counseling and all of them could have benefited from such counseling in reaching a decision they genuinely wanted to make—one they were not likely to regret. The study revealed that adoption was rarely considered as an alternative to parenting or abortion. Among the multitude of factors which seemed to affect the decision to deliver or abort were: 1) desire for a child; 2) relationship with sexual partner; 3) support for decision; 4) role models; 5) attitudes toward abortion; 6) previous pregnancy history; and 7) timing of the pregnancy.

"These findings strongly suggest that the decision about the outcome of the pregnancy in this population is related more to the circumstances surrounding the particular pregnancy than it is to any stable characteristic of the woman herself," Klerman declared. This research also indicates the need for more investigation of the role of the partner in the decision-making process. Klerman noted. Additional data from the study, showing that the partner is much more likely to oppose a decision to abort than to deliver, further reveals the important role he plays in the decision.

A study of the service needs of young parents[24] conducted by James F. Jekel, associate professor of public health, Yale University Medical School, and Janet B. Forbush, executive director, National Alliance Concerned with School-Age Parents, revealed that few, if any, of these needs were being met through existing programs. The study was based on responses to a two-part questionnaire distributed to 34 participating programs in 11 states. The 890 respondents included both young parents and service providers. A large proportion of both providers (10% to 20%) and young parents (29% to 30%) did not know enough about how needs were being met, particularly outside the programs, to answer items on the questionnaire. Young parents tended to see education, particularly in skills for living a competent, independent family life, as being more important than other services. Providers tended to rate these services as important but also showed pronounced interest in making available services that might contribute to dependency rather than independence.

Research on Cognition

Michael Baizerman, associate professor, Center for Youth Development and Research, University of Minnesota, presented a paper hypothesizing about the thinking processes of young pregnant women.[25] According to the rational view, pregnancy is not usually accepted as an accident because there are ways to prevent it; pregnancy is accepted as an accident only when these ways fail through some technical difficulty or human error, Baizerman explained. However, the accident view of pregnancy can "make sense" to the young woman who becomes pregnant if she does not know the physical facts about pregnancy or if she has the facts but does not know what they mean. This latter point is related to cognitive development, Baizerman emphasized, and is an important consideration for anyone working with adolescents. On an emotional level pregnancy can be explained as an accident regardless of the validity of the theory of

cause or prevention, Baizerman suggested. If on some internal level the young women feels she did not intend to become pregnant, she can accept this as proof that the pregnancy was an accident. She may feel guilty about the sex act and the accident of her pregnancy becomes "proof of punishment"; or she may see herself as not sexually active, hence not in need of contraception; or she may have found herself in a situation she could not control involving drugs or alcohol. These considerations should be taken into account by anyone who hopes to understand the young woman on her own terms, according to Baizerman.

These hypotheses on adolescent thinking tie in with other research on cognition. Up until recently researchers have taken a narrow view of the change in cognitive structure that usually takes place in adolescence. Based on the theories of Jean Piaget, adolescents experience a shift in their thinking process from concrete operations, or the ability to reason on the basis of objects, characteristic of childhood, to formal operations, or the ability to reason on the basis of abstractions and symbols, more characteristic of adulthood. This change, which is even more variable at age of appearance than physical changes, may begin in some persons at age eleven, in others not until the early twenties, and in some persons not at all.[26] The impact of this great variability in cognitive structure has not been studied. There is a need to acknowledge the diversity and complexity of adolescent thinking and how this intellectual process may be affected by physiological and socioemotional factors. Great emphasis has been placed on the years from one to four in early childhood education but there has been very little realization of what this crucial shift in the thinking process means in the psychology of adolescence.

Hill notes that the "Americanization of Piaget" has deemphasized the importance he places upon organismic adaptation to the environment. Hill points out that little work has been done on the possible sociocultural determinants of the age at onset of the various cognitive abilities. The interrelationship of body type, social class, sex, and age have barely been explored.[27] In early adolescence physical development and sexual maturation vie and interact with the development of cognitive skills and emotional expressiveness. What is the impact of early physical maturation upon cognitive maturation? Early maturers often become less exploratory and less intellectually curious. Early physical development for females in our culture involves a different form of social pressure than for males. Adolescent girls, for heterosexual social reasons, may be more likely to apply formal operational thinking to interpersonal relationships rather than, for example, the study of science.[28]

Lipsitz cautions us to be wary of Piaget's theories simply because they dominate the field. She notes that Skinner believes that learning is not developmental but cummulative. This difference is extremely important in approaching such practical areas as programmed learning. "We expect practitioners to deal with it on a day-to-day basis through materials and procedures which may be based on diametrically opposed approaches to learning. It may well be that cumulative learning theory undergirds practice while developmental learning theory undergirds research."

William D. Rohwer, Jr., is also interested in the shift in the learning process that occurs from early childhood to adolescence. In his experiments involving adolescents[29] who do not perform optimally under conditions of minimal prompting, he theorizes that they lack only a problem-solving orientation toward learning and memory tasks. He is interested in whether problem-solving orientation could be achieved through training provided at critical times for the learner.

Cognitive Development and Teenage Sexuality

This theory ties in with the work of W. Godfrey Cobliner. In an article on "Pregnancy in the Single Adolescent Girl: the Role of Cognitive Functions,"[30] he reports on a study of 211 single adolescent women who had undergone an elective abortion at a municipal hospital in the New York City metropolitan area, and 200 single adolescents pregnant for the first time. The interviewers discovered widespread lack of planning, irrational thinking and risk taking attitudes among the sexually active young women. However, as soon as they became aware of their pregnancy they were "galvanized" into defensive action. Cobliner suggests that this reaction has something to do with the Piagetian model of the adolescent thinking process. He notes, "when adolescents get pregnant they are being constantly reminded of their state by physical sensations and therefore will mobilize all their resources and overcome obstacles, inhibitions and fears to deal with a pressing situation because it is ubiquitous and continually forced into their place of awareness. In this case figurative thinking (concrete operations) is good enough to result in adaptive action."

Cobliner points out that while figurative thinking depends on feedback, operative thinking (formal operations) constructs models of action (contraception) and puts them into effect before the situation (pregnancy) materializes. Since many adolescents have not yet reached the stage of formal operations or operative thinking, Cobliner suggests the use of "constant and effective stimuli that act on their imagination, like those employed in cigaret advertising" in order to "set up necessary feedback loops for action, namely contraceptive practice."

The implications of adolescent cognitive development for the use or non-use of contraception is the subject of a 1975 study by George Cvetkovich, Barbara Grote, Ann Bjorseth, and Julia Sarkissian.[31] They maintain that while the presentation of accurate contraceptive information is important, it is not in itself sufficient, since "one of the most striking characteristics of teenage illegitimacy is that many adolescents who have the benefit of the best sex education and have available contraceptive materials, do not use contraception." They point out that research in this area has been inadequate because it has generally followed a one-shot, attitude survey model (e.g. the Kantner and Zelnik point-in-time analysis of adolescent attitudes).

Of primary importance is the adolescent's evolving self concept of her or his sexuality which these researchers examine in a Piagetian framework. "The adolescent may not be ready, cognitively or emotionally, to accept his sexuality to the degree that allows premediated sex. To prepare for sex by using contraception is to admit to self and the imaginary audience a willingness to accept adult sexuality."

Among the serious shortcomings of existing studies, these researchers point out, is the lack of information on males.

"We have not uncovered a single in-depth analysis of male adolescents regarding contraception." They call for an in-depth, longitudinal research strategy that would follow male and female adolescents from sexual inactivity to early sexual activity and young adulthood.

Although the sample is small (334), a 1971 study by Warren B. Miller, "Sexuality, Contraception and Pregnancy in a High School Population,"[32] illustrates the value of including both males and females in such a survey. The subjects attended two San Francisco Bay area high schools, one predominantly white and middle class, the other racially and ethnically mixed and lower class. The study brought out significant differences in male and female attitudes as well as those of the socioeconomic classes. For example, women, especially those in the lower class, were more likely to be sexually active while disapproving of it; and lower class males had less orientation toward oral contraceptives and more toward less effective methods.

In other studies of the psychological implications of abortion and unwanted pregnancy for young women,[33] Miller points out the difficulty some women, especially passive types, have in discussing their contraceptive preferences with their male partners. He notes that female initiative in contraception implies assertiveness, even aggressiveness, which runs strongly counter to traditional views of female sexuality. Early adolescence is among the most psychologically vulnerable stages for unplanned pregnancy, he observes, because the young woman has not yet learned contraceptive vigilance—it is not yet a "natural process" for her.[34] Because oral contraception separates sexual behavior in time and space, he suggests, it avoids many of the problems of other methods but it also has its own set of problems—pill taking is a daily task which needs motivation, which may be emotionally associated with feelings about intercourse or the relationship itself. All of these factors may also be influenced by cognitive development.

Need to Reorder Social Values

James W. Maddock, in a 1973 article on "Sex in Adolescence: Its Meaning and Its Future,"[35] points out the importance of the interrelatedness of biological, psychological, and sociological factors involved in adolescent sexual growth and development. He believes that there is a need to reexamine the meaning which sexual expression has within the total context of adolescent experience in our culture and society. Sex in adolescence need not be defined as a problem, Maddock suggests, although a problematic task may be integral to its expression by the adolescent individual.

He adds: "If the 'moratorium' character of adolescence is recognized, then some forms of sexual expression which are normatively and naturally 'identity-testing' exercises must be accepted. This is the direction in which today's youth seem to be moving. Can this expression include full heterosexual intercourse? Given the increasing separation of sex from reproduction, chances are it can. However, in order for this to occur on a successful basis, we must accomplish an entire re-orientation of our sexual values as these affect our social structures. This can only take place in the context of an entire re-ordering of American social values."

Such a reordering of social values is gradually and, in some cases, painfully taking place. However, as this brief survey of the research indicates, the problems of integrating, understanding, and accepting the consequences of adolescent sexuality, even among adolescents themselves, is enormously complex.

Need for a Link Between Research and Practice

Moreover, the time span from conceptualization to application of research in the field of adolescent pregnancy and sexuality resembles the pace of a turtle on a country road on a hot afternoon. The question of how best to use the existing research has not even begun to be adequately considered and the fact that there has not been enough research to make responsible judgments seems to have been overlooked.

NACSAP has attempted, through its national conference and its publications, to disseminate existing research and initiate new research into wider areas of the social, economic, and psychological consequences of adolescent pregnancy and early parenthood. But because of limited financial resources, this effort has been, at best, minimal. Both researchers and practitioners have repeatedly requested that NACSAP act as an information clearinghouse. Such a mechanism is in place. The existence of the research committee represents NACSAP's recognition of the importance of information dissemination. Even though lack of adequate funding has severely handicapped NACSAP's efforts, its research represents a more comprehensive view than that of other groups which have tended to focus only on the fertility or population aspects of adolescent sexuality.

The weaknesses in research methodology pointed out in 1971 by Baizerman et al and reinforced by Stewart's 1976 critique have still to be addressed. Most studies are based on small samples of select populations. There is not enough attention given to the ecology of the problem—i.e. the interrelatedness of age, race, socioeconomic status, etc.

The following questions are a small sampling of many that could serve as the basis for additional research:

- Can the crisis situation that usually surrounds adolescent pregnancy and parenthood be turned into a learning experience? Studies have shown that such a time "galvanizes" adolescents" ability to act. How can the strengths of adolescence—optimism, courage, adaptability—be used in such a situation?
- Some programs have found that the anxiety level of younger pregnant women—between ages 11 and 15—is exceptionally high. Many return each week with the same fears and questions. How is this related to their cognitive development?
- Naiman[36] sought to test the hypothesis that guilt was of etiological significance in unmarried pregnancy. The findings did not support this but it was found that sexual impulsivity was etiological. How is sexual impulsivity affected by cognitive development?
- Baizerman et al stressed the need for explicit theoretical research models, noting that when the model is not clear the reader can be easily lost (or convinced) as he follows the author's findings, analyses, and conclusions. How does this apparent need relate to studies published in sources with a specific point of view?

- How does the dyadic context of sexuality affect adolescents who are struggling to establish their own individual identity? How does this affect their ability to communicate wishes and/or desires about contraceptive practice?
- How does cognitive development affect action when the causative process (contraception) is not linked in time with the outcome or result (pregnancy)? How is this affected by a younger person's present-oriented thinking process?
- How do certain assumed psychological traits of adolescence—risk-taking, difficulty in accepting oneself as a sexual being—work against contraceptive practice?
- Many of today's young people are questioning traditional attitudes toward marriage and childbearing. How does this affect their decisions about sexuality and parenthood?
- Could adolescent sexuality represent a domain of décalage—adolescents are being asked to make decisions about contraception at a time when they are sexually undifferentiated and unprepared for such analytical thinking about themselves?
- Does teaching sex education solely as an academic subject mean that questions which, from the adolescents' viewpoint, are the most important, go unanswered because they may be too embarrassed to voice their concerns? Can peer counseling—with older adolescents instructing younger adolescents—work to fill these information gaps?
- How does the fact that sexual standards are a wholly subjective area of human reaction and interaction affect research hypotheses and findings?
- Can an adolescent who reports on his or her sexual behavior in a one-shot survey be considered sexually active?
- Is it possible to obtain objective information on the effectiveness or ineffectiveness of various types of contraception? How is this information affected by male domination of contraceptive manufacturing, advertising, and research?
- How does method and style of parenting influence an adolescents' development within the family unit? Do these parental role models influence his or her own parenting style? How does this affect varying levels of decision-making about childbearing and childrearing?
- How can the concept of a services program for adolescents be actualized when adolescents have been isolated from its development? Do adolescents view those services, allegedly established for them, in the same ways as do the adults responsible for their development? If perceptions of "service" are so vastly different, how does this predispose effectiveness?

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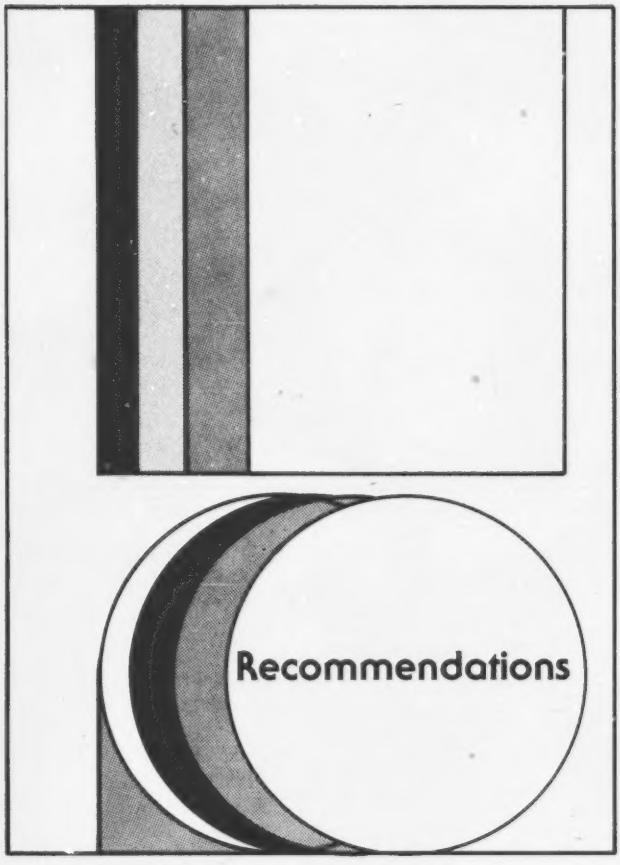

Background

The public is yet today largely unaware of the complexity of issues involved in school-age pregnancy and parenthood and adolescent sexual behavior. While media has played up the sensational side of the issue by emphasizing statistics that lead to a belief that the country is in the midst of an epidemic of teenage pregnancy, such a view, based on statistical data alone, is comparable to stating that you know everything about a city after viewing it from the air.

As a result of expanded media coverage, there is evidence that the public has made an assumption that increased public attention to this issue has attracted additional dollar support for programs and services. Unfortunately, this is not the case. Foundations, for example have been generally more oriented to population-related aspects of this issue. Corporate sector funding sources view the issue with extreme caution, not wanting to infringe on the attitudes and values of their stockholders.

Despite what would appear to be a more receptive social climate, intervention in the area of sexuality—especially adolescent sexuality—is still met with formidable barriers. Because the social forces operating in our society are complex, with many levels of values to be considered, even more sensitivity is required when relating to this issue today than might have been necessary a few years ago.

Building on the experience of practitioners who have been involved in remediation can provide a realistic view of sexually active youth and can contribute greatly to a primary prevention strategy with a pre-school population which could ultimately enhance the general prevention approaches in regular school settings, church groups, etc. Futuristic thinking in this field has been handicapped because of the minimal resources available to program people. They are forced to deal with today's needs rather than anticipating tomorrow's.

However, if collaborative leadership is assumed for impacting on this issue by foundations, government agencies, and corporate funding sources, it is more than likely that the adult lives of the young parents of 1977 will be influenced for the better.

What Can Be Done

NACSAP views this paper largely as an outline or a beginning statement of the issues involved in school-age parenthood and pregnancy. Each segment could be expanded to represent an important document in and of itself. If resources were made available, NACSAP is prepared to expand the statements in each of the areas by enlisting the involvement of experts throughout the country.

Based on present information, NACSAP predicts that there will be no dramatic change in the phenomenon of adolescent pregnancy and school-age parenthood within the next five years. This prediction is based on a judgment of policies and program efforts now in place which are too few in number and too new and unproven to demonstrate that they can bring about change in adolescent sexual behavior.

Therefore, NACSAP recommends that foundations and corporate sector funding agents establish adolescent pregnancy and parenthood as a primary interest area for the next five years, designating to appropriate divisions within their organizations the responsibility for developing plans to impact on the issue with the following priorities in mind:

- *Technical Assistance*—Foundations and corporate groups are encouraged to fund projects which promote technical assistance to agencies now providing services to school-age parents, pregnant adolescents, and sexually active youth to help them improve ways of impacting on the needs of young people in both remedial and prevention modes. Recognizing that resources already exist that are not presently directed toward this at-risk population, the emphasis of technical assistance projects would be to promote creative use of existing resources.
- *Documentation*—Foundations and corporate groups are encouraged to promote historical documentation of the multidisciplinary school-age parent program strategies developed since the mid-1960s in several communities throughout the country. Documentation is particularly urgent for school-age parent programs with fairly rapid turnover so that expertise developed in particular service areas is not lost.
- *Guidelines*—Foundations and corporate groups are encouraged to support the publication of current documents illustrating approaches for providing health, ed-

ucation, and social services to young parents and sexually active youth. Publications developed in the early 1970s are either out of print or are already outdated. Such new guidelines could be augmented with an explanation that would translate the unique experience o. multidisciplinary intervention strategy for use in other social change efforts which cut across several disciplines. In addition, such guidelines would foster development of an accreditation structure for existing school-age parent and/or related youth programs.

- *Pre-service and In-service Training*—Foundations and corporate groups are encouraged to convene a meeting of selected representatives of several universities, colleges, and professional associations to consider a cost-effective strategy for providing both pre-service and in-service training to those who are now or will soon be working with adolescents, particularly sexually active youth. To date there have been only a few attempts to relate to the training curricula available in professional schools.
- *Funding*—Foundations and corporate groups are encouraged to convene a meeting of appropriate representatives of their organizations to discuss possible interest on their part in funding new projects in this area or relating existing projects in the field of adolescence to adolescent sexuality and parenthood. If this were to occur, it is advised that the foundations and corporate representatives consider funding separate strategies for big city and rural programs.
- *Youth Participation*—Foundations and corporate groups are encouraged to promote projects that will enhance the involvement of youth in the decision-making processes of both remedial and preventive aspects of school-age parent programs. Of particular concern should be the lack of classroom materials for use by pregnant adolescents and adolescent mothers. Despite some new parenting education materials developed through funds provided by the National Foundation-March of Dimes and the Office of Child Development (now DHEW's Administration on Children, Youth, and Families) they speak only to selected members of school-age parent classes and in some cases not to this group at all.
- *Research*—Foundations and corporate groups are encouraged to support research that will establish a knowledge base on the long-term effects of adolescent parenthood, especially in relation to the offspring of young parents and/or their extended family units. Continuing research on adolescence should also be encouraged. *Growing Up Forgotten*, the investigation of research in the area of the pre-teen years by Joan Lipsitz, was a particularly useful document for this paper. Another priority should be research which bridges the gap between the universities and appropriate field units or advocacy organizations that are in close touch with practitioners. This would help relate current research to priority areas as they have been identified by service providers and further the practical application of such research. Within the context of continued support for research on adolescence, the entire behavioral domain of adolescence should be considered, including cognitive functions, adolescent needs systems and their decision-making processes as they relate to moral and ethical development.

Specific approaches on any of the above recommendations could be developed along several different avenues.

In conclusion, it is important to point out that current initiatives within the Department of Health, Education, and Welfare suggest the possibility of considerable dollar support in some of the areas listed above during Fiscal 1979. There is also the possibility of redirecting some Fiscal 1978 DHEW funds to address critical program areas in this field. However, the process involved in securing those funds, if they are made available, will be lengthy and will, in any case, need additional dollar support from foundations and corporate sources to make a noticeable impact on an issue as complex and compelling as adolescent pregnancy and parenthood.

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